Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 38001 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Pottle 2004 /Medical November 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) ManoKin Somerse Manar 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 200F Months Director 218-16-8448 Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Executive frust be notified at Yes 2 □ No Director Princess Anne Maryland Somerset 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 21853 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. If the 12 1s marked other then "natural", or Itel other treumatic event, In Modifical Eventuals. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Inspector none Campbell Soup Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Olan A. Jones Millie S. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie McInturff/Daughter 24689 McInturff Road, Dames Quarter, MD 21821 e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If itel
any injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Johns U.M. Cemetery 11-10-04 Deal Island, Maryland Signature of Funeral Service Monsee 22. Name and Address of Facility Hinman Funeral Home 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Princess Anne, MD 21853 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 45000 /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 Yes 2 No 3 Probably this certificate has been 24a. Was an autopsy performed Division of Vital

Hospitel or Attending Physician:

To the

filled in by within 24 hours after of To the Funerel Directornoletely filled in by

: After this certifical funeral director, p Be Certification: To after death.
I Director: Aft
od in by the fur

1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner? 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manyer of Death 1 Natural

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier

4 Momicide

147094

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

57,, 5. DIVISION

SACISBURY MI 21804

State Registrar 31. Date filed (Month, Day, Year)

NATESTO

32. Registrar's Signature Eleve & Speed

1415

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Co. 4

	Oerui	ficate of Death	Reg. No.
Physician /Medical	1. Decedent's Name <i>(First, Middle, Last)</i> Beatrice Faye Paugh	2. Date of Month Nover	nber 20, 2004 3. Time of Death 4:30 AM
Examiner	4a Fecility Neme (If not institution, give street and number) Dennett Road Manor Nursing Home	4b. City, Town, or Location of De Oakland	eath 4c. County of Death Garrett
Funeral Director	308-64-9535 1□ M 2፟M F 87 Yrs. N	f Under 1 Year   If Under 24 Hrs.   8. Date of Month, O 1 - O 1	Birth Day, Year) -1917  9. Birthplace (State or Foreign Country) Barnum, WV
yland	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Locat	ion	10d. Inside City Limits
he Mai	MD Garrett Oakland		1 Yes 2 No
3a or 3	10e. Street end Number 1113 Mary Drive	10f. Zip Code 21550	10g. Citizen of What Country? USA
permit. Pages 1 end 2 should be tilad within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at pince.  To Be Completed by Funeral Director	11. Maritel Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent Ever in U,S. 14. Never Married 27 Married 11 DVss 25 No.	S Decedent of Hispenic Origin? (Specify Yes or es, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2ki No Specify:	No- 14. Race - American Indian, Black, White, etc. Specify: White
led within 72 hours it lygiene. her than "natural", of it, the Medical Exe Completed by	15. Decedent's Education 16a. Deceden (Specify only highest grede completed) (Give kin	's Usual Occupation d of work done during most of working NOT use retired)	16b. Kind of Business/Industry
d withir piene. r than me w	Elementery/Secondary (0-12) College (1-4or 5+) Houset		Homemaking
d other Hygen of other o	17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Midd	dle, Maiden Surname)
should ad Men marke marke	James McNamar  19e. Informent's Name/Relationship (Type, Print)  19b. Mailing /	Elvie Wilson Address (Street and Number or Rurel Route Nur	mber City or Town State Zio Code)
and 2 sauth er 27 is er trau		etery Hill - Swanton,	
ges 1 et for He H frem or other	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Plece of Disposition cemetery, cremati	on (Name of Date ory or other place)	20c. Location - City or Town, State
it. Pagintmen	4 □ Donation 5 □ Other (Specify) Mt Zion Ce	metery 11/22/04 ame and Address of Facility	Swanton, MD
Depa Impo Impo Ince	Day	vid A. Burdock Funeral ) Church St. Kitzmille	er, MD 21538
indicate be executed and ging physician and see as the burial-transit medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a.   atherosclerotic cause. Due to (or as a consequence of the consequence of the cause of the c	nce of):	5 years
daath daath de atten	Part II. Other significant conditions contributing to death but not resulting in the under	riving cause given in Part I. 23b. D	id tobacco use contribute to the cause of death
as thet the daath cer gned by the attendin be datached for use by Physician/N	diabetes mellitur type two, chronic re		☐ Yes XX No 3 ☐ Probably 4 ☐ Unknow
To the Hospital or Attending Physician: The lew requires that the death cen within 24 hours after death within 24 hours after death within 25 to the Lanesta Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/N		24a. W	24b. Were autopsy findings available prior to completion of cause of deeth?
cata he paga		11	☐ Yes 2 No 1 ☐ Yes 2 No
sician certifi irector	25. Was case referred to medical examiner? 1	26. Plece of Death (Check on.	ly one) esidence 6 □Other (Specify)
ath.  ": After this c at funaral dir.	27. Menner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation 28b. Time of Injury		be how injury occurred
its or Attending P its aftar death.  al Director: After t lad in by tha funar  Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	City or	n (Street and Number or Rural Route Number, Town, State)
the Hospi nin 24 hou the Funer npletaly fill	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death or provided in the basis of examination and/or invessand manner stated.	tigation, in my opinion, death occurred at the tim	ne, date and place, and due to the cause(s)
To the common N	29b. Signature end title of centrier  William Milliam Milliam MA	29c. License number D0025759	29d Date signed (Month, Day, Year) November 20, 2004
	30. Name end address of person who completed cause of death (Item 23a) (Type, Pri Walter K. Naumann, M.D., PO Box 247, A		
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signature		

DHMH 16 Rev 6/95

		•	= For Amend Items 23a, b, 25, 27, 2	ind/De 28a-f	partment of Health Perfificate of Deal	h and Me 2/01/04	ental Hygi dhb	eng 004	38003
			Decedent's Name (First, Middle, Last)			1	2. Date of Death Month	Day Yee	3. Time of Death
	Physicia /Medic		CLEO R. PARRISH			(	October	14, 2004	4:15 a <sup>™</sup>
5	Examin		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or Location	ion of Death		4c. County of De	
A			Atlantic General Hospital  5. Social Security Number 6. Sex 7. Age (In y.	rs. last birtho	Berlin	der 24 Hrs.	Date of Birth	Worches	Irthplace (Stete or Foreign
	Funeral Director		577-36-3486 1™ 2□F 78		Months Davs Hour	rs Min.	Month, Day, March 13,	1926 I	Country) Llinois
	and ow		Usual Residence of Decedent           10a. State         10b. County         10c.	City, Town o	r Location				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	tor	Maryland Frederick Un	ion B	ridge				1 ☐ Yes 2X No
	n the	Directo	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?
	23a c		12837 Bunker Hill Road		2179			U.S.A.	
	within 72 hours after death with the Marylan jiene. Then' natural, or Items 23a or 28a-f show then' then' hatdrel Examinat must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give W Year or Dates:	WII	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 ☐ Yes 2 ☒ No Specify Cuban, Mexi		ify Yes or No- ican, etc.)	14. Race - Ar Black, W Specify: To	
2-003b	72 hou natura dical E		15. Decedent's Education (Specify only highest grade completed)		ecedent's Usual Occupation live kind of work done during n	most of working	, 1	6b. Kind of Busine	ss/Industry
7	within 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	li	e. DO NOT use retired)		I	Federal	
7	e filed w Il Hygier other th		12 17. Father's Name (First, Middle, Last)	Lice	ensing Supervi			Communicat: Naiden Sumame)	ions Commission
Maryland	₩ da b >	) Be	Rush Cleo Parrish				adys Hal		
2	s 1 and 2 should be f Health and Menta Item 27 Is marked other traumatic ev	은	19a. Informant's Name/Relationship (Type, Print)	19b. N	ailing Address (Street and Nur				, Zip Code)
	nd 2 lith a 27 ls r trai		Paul William Parrish - Son	128	337 Bunker Hil	1 Road,	Union	Bridge,	MD 21791
or G	of Head		20a. Method of Disposition 20b 1 № Burial 2 Cremation 3 Removal from State	p. Place of D cemetery,	isposition (Name of crematory or other place)	Da	te 2	Oc. Location - City	or Town, State
Ĕ	Pages ment of ant: If It lury or o		'4 □Donation 5 □Other (Specify)	ate of	Heaven Cemetery	1			
Baltimore,	permit. Pages Department of Important: If I eny injury or once.		21. Signature of Funeral Service Licensee		22. Name and Address of Fa 4739 Baltimor				·
	,		23a. Part1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	eath. Do not	enter the mode of dying, such	h as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Causa (Final disease or condition resulting in death)  a. Head Trams	Large	e Subdural Hem	atoma	and cer	vical	
	Examiner		Due to (or as a cons		spine fractur	ce			
		Jer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			70	00		
	cuted nd ransit	Examine	that initiated events		- C	10			
Ď	e exercien ar urial-t	Ex	resulting in death) Last Due to (or as a cons	sequence of)	NAM	TOWED BY MED	CALE		
28/60	ficate be executed physicien and s the burial-transit	edical	d		CERTIFICATION APP	BROAFE			
O. Box 6	death certii e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   9   Unknown	etal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		<u> </u>	23d. Date of o	delivery Day Year
٦.	res that the igned by be detact	/ Ph	Part II. Other significant conditions contributing to death but not	resulting in th	ne underlying cause given in Pa	art I.	23e. Did tob	acco use contribute	to the cause of death?
rds	quires nn sign uld be	ed by					1 ☐ Ye	s 2⊠No 3□	Probably 4 Unknown
Records,	The law requires that the sate has been signed by the page 2 should be detached.	Completed					24a. Was an autopsy perform	y prior t led? death	autopsy findings available o completion of cause of ?
Vital R	sician: Th certificate rector, pag	0	25. Was case referred to medical		26. P	Place of Death	1 Yes 2		es 2 No
	Physici this cer al direc	To B	examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2	ER/Outp	atient 3 DOA Other: 4	Nursing Hom	e 5 🗆 Resider	nce 6 Other (S	pecify)
n of	ng I		27. Manner of Death 28a. Date of Injury 1 □ Natural 5 □ Pending (Month, Day Year	28b. Tim Inju	ry Work?			w injury occurred	
<u> </u>	tendi death tor: /	cati	2 Accident investigation 2 Solicide 6 Could not be	Unkno	own 1 ☐ Yes 2	-	Subject		Rural Route Number,
Division	after after Direction by	Certification;			, street, factory, office		City or Town,	State) 507 P	enquin Dr.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier  (Check only  29 Medical Examiner: On the basis of exam		leath occurred at the time, date or investigation, in my opinion,	e and place, ar death occurred	nd due to the ca	use(s) and manner te and place, and o	Ocean City, as stated. MD ue to the cause(s)
	o the ithin 2 o the	Med	one) and manner stated.  29b. Signature and title of certifier		29c. License numb			d. Date signed (Mo	
)	F≯F8		July Thous	emort		8130		11/1/0	+
			30. Name and address of person who completed cause of death (	Item 23a) (T)		5			
			Hen Hany Drive	Ben		1811			
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Si	gnature					

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		1 For State			d / Depa	artment of H	lealth ai	nd Mental Hy		_	
		- Hegistrar	and and		Cel	rtificate of	Death	100.10	Reg. No	F 0 0 4	00001
Physici	an	1. Decedent's Name (First, Middle, l Jeanette Marie						2. Date of De Month	aath Da	y Year	
/Medic		4a. Facility Name (If not institution, g		ər)		4b. City, Town, o	r Location of	NOVEMB]		8,2004 County of De	1:23P. M
Examin	er	I70 at ST.JOHNS		,						- 111	aui
Funeral			C 7	Age (In yrs.	last birthday)	ELLICOT If Under 1 Year	If Under 24	4 Hrs. 8. Date of Bi	rth	OWARD 9. Bj	rthplace (State or Foreign
Director		231-11-0783	1□M 2☐F	27	Yrs.	Months Days	Hours	Min. Jan. 1	6, 90		i <b>r</b> ginia
pu 🔹		Usual Residence of Decedent  10a. State 10b. County		10c Cib	y, Town or Lo	postion					Taga India on their
Aaryla eho	ō		aton								10d. Inside City Limits 1 Tyes 2 XNo
28e-1	Director	Maryland Washin  10e. Street and Number	gron	ВО	onsbor	10f, Zip Code			10a Cit	tizen of What C	
aa or	0	18036 Herr Lane				21713					ounity:
death ms 2	by Funeral	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13.		lispanic Origi	in? (Specify Yes or No Puerto Rican, etc.)		SA 14. Race - Arr	
or its	F	1X Never Married 2☐ Married	Armed Force 1 Yes 2 ( If Yes, Give					Puerto Rican, etc.)		Black, Wh	
ural',	d b	3 Widowed 4 Divorced	Year or Date	s:		1 ☐ Yes 2 🔀 No	Specify:			Specify: Wh	ite
natu	Completed	15. Decedent's (Specify only highest of	Education grade completed)		(Give	dent's Usual Occup kind of work done	durina most d	of working	16b. K	and of Busines	s/Industry
withir ene. then	ф	Elementary/Secondary (0-12)	College (1-4d	or 5+)		DO NOT use retired ency Medi	•	ech.	Amb	ulance	Transport
filed Hygi other ent. I		17. Father's Name (First, Middle, La			201 9	che, near		s Name (First, Middle			Transport
ld be lental ked o	To Be	John Ronald Ros	eberrv				Teres	sa Yvonne	Hood	,	
shou and N s mai		19a. Informant's Name/Relationship	<del>'</del>		19b. Mailir	ng Address (Street		or Rural Route Numb		or Town, State,	Zip Code)
and 2 saith a n 27 th		Teresa Y. Obitt	s - Mother	•	18036	Herr La	ne Bo	onsboro,MC	217	713	
of He		20a. Method of Disposition 1	□Removal from Sta	20b. P	lace of Dispo emetery, crer	sition (Name of matory or other place	(e)	Date	20c. Lo	ocation - City o	r Town, State
Pag Iment tent: jury c		`4 Donation 5 Other (Spec	city)		nor Ce		Nov	v.23,2004	Воо	nsboro,	Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then *natural', or Itams 23a or 28e-f ehow any injury or other treumatic event. Its Medical Exatt and train Le Indiffical at 200ce.		21. Signature of Funeral Service Lic	94560		22	2. Name and Addres	ss of Facility	Osborne F	uner	al Home	e,P.A.
40200	-	23a Barti Enter the disease or on	maliantiana that assu	and the death	4;	25 S.Conc	cochea	ague St.	Will	iamspor	+,MD 21795
		23a. Part1. Enter the distase, or co shock, or heart faill re. List on Immediate Cause (Final	ly one cause on each	n line.			g, such as ca	ardiac or respiratory a	irrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a_MUL	hole		ries					
Examiner			Due to (or a	as å consequ	uen ·sar):						
	Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequ	uence of):						
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s be executed sician and burial-transit	ĒX	resulting in death) Last	Due to (or	as a consequ	uence of):				-		
death certificate b attending physic	dicai		d								
ding	/Me	IF FEMALE:	23c. If yes, outcom	ne of pregna	DCV						
atten atten I for u	ciar	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnant	2 🗌 Fetal	Ideath 3□	Ectopic pregnancy Other (specify)				23d. Date of de Month	Day Year
the d by the ached	Physician/Med	1 Yes 2 No 9 Unknown	9□ Unknown								
w requires that the de been signed by the s should be detached	by P	Part II. Other significant conditions	contributing to death	h but not rest	ulting in the u	nderlying cause give	en in Part I.	23e. Did t	tobacco u	use contribute t	to the cause of death?
aquire en sig	pa							1	Yes 2	<b>К</b> 0 № 3 🗆 ғ	robably 4 Unknown
law ras be	ple							24a. Was			utopsy findings available completion of cause of
The ate h page	Completed							perfd و ا	ormed?	death?	
iclen: certific ector,	Be	25. Was case referred to medical examiner?	Hospital			0#		of Death (Check only o	one)		
Phys this al dir	. T	1Æ Yes 2☐ No 27. Manner of Death	Hospital: 1 🗀 Inpa		ER/Outpatien 28b. Time of		4   Nuis	sing Home 5 Resi			ecify,SCENE
ding h. After fune	tion	1 □Natural 5 □ Pending 2 🛣 Accident investigat	(Month	Day Year)	13:4	Wor	k? Yes 2.∏No	driver ?	San	Joures (	e involved
Atter r dea sctor by the	ifica	3 ☐ Suicide 6 ☐ Could not	be 28e, Place of	Injury - At ho	me, farm, str	eet, factory, office		IN CO	Street an		lural Route Number,
s afte s afte el Dlr	Certification:	4  Homicide	building,	etc. (Specify	in	terstate	- high	wy I 70	ade of	24.00	Rural Route Number,
hour hour unere		29a. Certifier  (Check only 27 Medical Ex	Physician: To the be	st of my kno	wiedge, death	occurred at the time	ne, date and	place, and due to the	cause(s)	and manner a	s stated.
To the Hospitel or Attending Physiclen: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	Medical	(Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the one)									e to the cause(s)
To To con	2	29b. Signature and title of certifier	000	20		29c. License	e number		29d. Dat	te signed (Mon	th, Day, Year)
. 1		Toll Un	Tolk	2	ms		M.E.	N	OVEM	IBER 19	2004
4-4		30. Name and address of person wh	o completed cause o	of death (Item	23a) (Type,	,					
Sta	te	31. Date filed (Month Dev. Year)	32. Regi	strar's Signa		•	Stree	t, Baltimo	re,	Maryla	nd 21201
Registr		NUV 22	2004	us l	4. An	ede					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 932 Louise Virginia RUTH 20,200 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) March 31, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X Yrs. 76 Director 219-20-4999 1928 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-1 show other traumatic event, the Medical Evantible; and be notified at 1⊠Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 846 Guilford Avenue 21740 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Essie Hinton Oscar Eckard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other trau C. Allen Ruth Sr. - husband 846 Guilford Ave., Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 11/22/04 Hagerstown, Maryland Hagerstown Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22) Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 Approximate Interval Between Onsel and Death Fart1. Enter the disease, or complications the shock, or heart failure. List only one cause in caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, aach line. Immediate Cause (Final **Physician** ay disease or condition resulting in death) /Medical Dual (or as a consequence of): Examiner 10080 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner law requires that the dea h certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ending physician Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atte for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has 1 ☐ Yes 2 - 1 No Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 2 1 🗌 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannes 28b. Time of 28d. Describe how injury occurred Certification: After Hospitei or Attending 1 etural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and ti 29d. Date signed (Month, Day, Year, 30. Name and and 31. Date filed (Month, 32. Registrar's Signature Registrar

		1 - For State Registrar	State of	Marylan	d / Depa <i>Cei</i>	artment rtificate	of Hea	ith an ath	d Mental H	ygiene Reg. No	2004	38006
Physici	an	Decedent's Name (First, Middle	, Last)						2. Date of Month	Death Da	y Year	M
/Medic		Sheila A. Ryan  4a. Facility Name (If not institution)	give street and num.	ber)		4b. City, 7	own, or Loc	ation of D	Novemb Beath		. County of Dea	
LAGIIII		Anne Arundel M				An	napoli	s			Anne A	
Funeral Director		5. Social Security Number 118–18–0198	6. Sex   7 1 ☐ M 2 ☑ F	'. Age (In yrs. I 76	ast birthday) Yrs.	Months		ours 1	Vin. (Month,	Day, Year)		rthplace (State or Foreign Country)
ס		Usual Residence of Decedent							Mar.	2/,19	28   Net	y York
death with the Maryland me 23a or 28a-f show	ř	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the M	Director	Maryland Montgo	omery		Si	lver	Spring Code	3		10g. Ci	izen of What C	
th with 23a or		15115 Interlache	en Drive#6	18			2090	16			USA	
er dea	Funeral	11. Marital Status	12. Was Deced	dent Ever in U. ces?	S. 13.	Was Decede If Yes, spec	ent of Hispar fy Cuban, M	nic Origin Iexican, P	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Am Black, Wh	
urs aft	þ	1 ☐ Never Married 2 ☐ Marri 3 🙀 Widowed 4 ☐ Divorced	ed 1 Tyes 2 If Yes, Give Year or Da	3 ~ "		1 ☐ Yes 2	⊠ No Si	pecify:			Specify:	White
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filed I Hygid other	Be Co	17. Father's Name (First, Middle, I	<u> </u>			emake.		Mother's	Name (First, Midd		n Home Sumame)	
Menta Menta Menta arked atic ev	To B	John Aloysius	Langan					Lyli	an St	uart		
12 sho hand 7 Isma reuma		19a. Informant's Name/Relationsh	, , , ,		19b. Mailir	ng Address	(Street and I	Number o	r Rural Route Nur	65 55	2003 2003	
permit. Pages 1 and 2 should be itied within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Branchant I them 27 is marked other then "natural; or Itame 23a or 28a-1 show any injury opother treumatic event, the Medical Examination must be notified at once.		Debra A. Gibbon 20a. Method of Disposition	is Daugh	20b. P	361 Bullace of Dispo emetery, crer	sition (Nam	e of		Date	20c. L	and 21 ocation - City o	r Town, State
Page In: File Page Page Page Page Page Page Page Pag		1 🔀 Burial 2 □ Cremation `4 □ Donation 5 □ Other (Sp		tate Gate	e of H	eaven	Cemet	ery	v.15,200	941	war Car	ifac Mi
ermit. epartn nports ny inju		21. Signature of Funeral Service I			Fr	2. Name and	Address of	Facility 11 in	s Funera	1 Hom	e Inc	1.053.20
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9 - 9	шо								— au pe 1 ☐ Yes	topsy rformed? 2210c	prior to death?	completion of cause of
Physiclan: Th r this certificate ral director, pag	Be C	25. Was case referred to medical examiner?	Honestell					. Place of	Death (Check onl			
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To the Hospitel or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier Certifyin	g Physician: To the l	hest of my kno	wledge deat	h occurred a	at the time of	late and n	lace, and due to th	00 001160/6	) and manner a	e Stated
24 ho	edicai		Examiner: On the ba	sis of examina								
	×	29b. Signature and title of certifier	10			29c.	License nu	mber		29d. Da	te signed (Mon	oth, Day, Year)
着以		1/9	/ John	L, M			10 37	036		41	SOCIKI	7
120		30. Name and address of person	who completed cause	of death (Item		Print)	10/10	ر قد	hute.	M3	2161	9
Sta		31. Date filed (Month, Day, Year)	32. RM	gistrar's Signa		100	eks		Thister.		•	
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			State of Maryland / Department of Health and  1- State Registrar Certificate of Death		jiene leg. No. 0 0	38007
	۰		1. Decedent's Name (First, Middle, Last)	2. Date of Dea	th	3. Time of Death
	Physicia /Medid		Rosa Kosanova	Month	11 20	Year 1050 AM
	Examin		4a. Fa <sup>c</sup> ility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea  Howard County General  Columbia	th	4c. County o	
-			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Funeral Director		220-25-5694 1□M 2疑F 55 Yrs. Months Days Hours Min	. (Month, Day	/1948	Country) Italy
	D .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		7 1 2 2 3	
	anyla shov	ō	MD Anne Arundel Laurel			10d. Inside City Limits 1 ☐ Yes 2 XNo
	28a-i	rect	10e. Street and Number 10f. Zip Code		I0g. Citizen of WI	hat Country?
	ilied within 72 hours after death with the Maryland Hygiene, Hydiene, ior Items 23e or 28a-f show that then "natural", or Items 23e or 28a-f show ant, ire Madical Examir er mat be notified a	Funeral Director	8314 Finchleigh Street 20724		USA	
	ems (	Iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)		- American Indian, , White, etc.
2	s afte	by Fu	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No Specify: Year or Dates:			White
3	2 hour				16b. Kind of Bus	iness/Industry
2	thin 7.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupation (Give kind of work done during most of work	orking		·
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2	ntal H ad oth	o Be		me <i>(First, Middle, i</i> a Fittip		)
<u> </u>	should be nd Mental markad o umetic eve	۲	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or R			tate. Zio Code)
Ĕ	C1 G 78 E2		Giuseppie Rosanova/Husband 8314 Finchleigh			
ָרָ מ	of Hei of Hei fitem rothe	1	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)			City or Town, State
	Pag ment ant: I		1 Depuriar 2 Cremation 3 Hemoval from State Mt.Olivet Mausoleum11	/15/04	Wash.	o.c.
Dalillo	parmit. Pages 1 and Department of Health Important: If item 27 any injury or other t		21. Signature of Funeral Service Lidensee  Philip D. Rinald 9241 Columbia	i Funer lvd.Sil	al Serv	vice,P.A. ring,Md20910
	si si		23a. Part 1. Enter n e disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory arre	est,	Approximate Interval Between
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5	ding Physician: The h. After this certificate h: funeral director, page	T :uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work?	28d. Describe ho		
	tendir leath. lor: A the fu	catic	2 Accident investigation M 1 Yes 2 No			
2	or At after d Diract in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town		or Rural Route Number,
_	spital	al Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the ca	ause(s) and man	ner as stated.
	To the Hospital or Attending Physician: within 24 hours after death To tha Funarel Director: After this certifics completely filled in by the funeral director, i	edicai	(Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence.	urred at the time, d	ate and place, an	d due to the cause(s)
	withi Toti	×	29b. Signature and title of certifier 29c. License number		/	(Month, Day, Year)
	5		D33627	/	VOV 11	,2004
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARMEN SAL 102724 Little Patr Xent Pkwy Co	VATERR	A, M.D	
	Sta	te	31. Date (iled (Month, Day, Year)  32. Begistrar's Signature	INNIBIA	IVID	
	Registr		NOV 15 2004 Sparks			

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ı	Physicia /Medic		1. Decedent's Name (First, Middle, Last) GANIYU		RAJI			2. Date of Death NOV. 1	Day Yea	3. Time of Death 6:00a M
	Examin	_	4a. Facility Name (If not institution, give 6715 Hamilto			4b. City, Town, or River	r Location of Death dale		4c. County of De	
	Funeral Director		5. Social Security Number 6. Sec 5 7 9 - 9 0 - 4 9 0 6	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April	1°5′,52 N	irthplace (State or Foreign Country) 1 geria
	Aaryland f ehow	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Prin		, Town or Lo					10d. Inside City Limits 1 ∑ Yes 2 □ No
	h with the P 23a or 28a- at by notif	Funeral Director	10e. Street and Number 6715 Hamilton	St.		10f. Zip Code 2073	7		Og. Citizen of What (	Country?
036	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other than "natural", or items 23a or 28a-f ehow event, the Modical Examinar must be notified at event.	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H I Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wi	nerican Indian, nite, etc. 3 1 a c k
21215-0036	l within 72 ho iene. r than "natur the Medical	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retired b Drive	during most of work d)	ing	D.C.	
Č	8 ta \$ ₹	To Be C	17. Father's Name (First, Middle, Last) Wahabi Raji				18. Mother's Name Amudala			
Mary	and 2 should I alth and Meni 27 is marker or traumatic		19a. Informant's Name/Relationship (T) Raolat Raji - D			-			City or Town, State tsville	, Zip Code) , Md . 20705
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke eny injury or other traumatic once.		20a. Method of Disposition  Y☐ Burial 2 ☐ Cremation 3 ☐ F  ' 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, cren	sition (Name of natory or other place d Natio	00)		oc.Location-City o	
Balti	permit Departn Imports eny injk		21. Signature in Funeral Service Licens	i Mates					II Mort shingtor	uary Inc. n,D.C.
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Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat			
Division of Vital	Phys this al di	tion: To	1X Yes 2 No  27. Manner of Death  1X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. injur Wor	4 □ Nursing Ho	me 5X Reside 28d. Describe ho	nce 6 Other (Sp w injury occurred	pecify)
Divisi	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (Str City or Town		Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai	29a. Certifier (Check only one)  1 ★ Certifying Phy 2 ★ Medical Exemi	sician: To the best of my kno- iner: On the basis of examinal and manner stated.	wledge, death tion and/or in	occurred at the fir vestigation, in my o	me, date and place, pinion, death occur	and due to the ca red at the time, da	luse(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To t COM	Σ	29b. Signature and little of certifier	Men	w-	29c. Licens	2 2 0 1	_	ed. Date signed (Mo	nin, Day, Year)
_	V		30. Name and address of person who co	ompleted cause of death (I/em	23a) (Type.	1900 .	e mas		wash	yfor DC
	Sta Regist		31. Date filed (Month, Day, Year) NOV 15 200	32. Registrar's Signa	ture	Locale	and the same of th			20003

		-	For State Registrar	State	of Maryland		artment of tificate o				ene O	04	38009		
	6 0		Decedent's Name (First, Middle,	Last)						Date of Death Month		Voor	3. Time of Death		
	Physicia /Medic		Agripina				Rad			venber	Day 10.	Yeer 2004	6:25 a <sup>M</sup>		
3	Examin		4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City, Town	, or Location of				ty of Death	33.23		
			Holy Cross Hos					Sprin	g		Mon	tgome	ry		
	Funeral		,	.Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. Id <b>90</b>	ast birthday) Yrs.	If Under 1 Year Months Day		Min.	Date of Birth (Month, Day, )		Cou	place (State or Foreign intry)		
	Director	-	132 16 7301 Usual Residence of Decedent						Au	gust 5	1914	Ro	mania		
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits		
	e-f st	ctor	Maryland Montgon	iery	Si	lver S	pring						1 □Yes XXNo		
	or 28	Director	10e. Street and Number				10f. Zip Code	e		109	g. Citizen o	f What Cou	untry?		
	ath w		12310 Lima Drive					904			US				
36	r 72 hours after death with the Maryland "natural", or Itema 23a or 28e-f show offical Experiment for notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed F	2 X No ive		Was Decedent of If Yes, specify Co 1 ☐ Yes 2 🔼 N	uban, Mexican	i, Puerto Hica	Yes or No- an, etc.)	BI	ace - Amer lack, White cify: <b>Whi</b> t			
9	2 hou		15. Decedent's				dent's Usual Occ			10	6b. Kind of	Business/Ir	ndustry		
215	within 72 ho ene. than "natur i e Medical	Completed	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work do DO NOT use ret	ne auring mosi ired)	t of working						
21	F	Con	12			E	lomemake					n Home	e		
p	0 7 5	Be	17. Father's Name (First, Middle, La	ist)				18. Mothe	er's Name (Fi	irst, Middle, Ma	aiden Suma	атө)			
Yla	should be fi nd Mental F marked ot imatic ever	၉	Unknown			101 14 15	- 111		known		01 T	- 04-4- 7	in Contain		
Maryland 21215-0036	12 sh h and 7 Is m traum		19a. Informant's Name/Relationshi		7		ng Address (Stre				-				
	permit. Pages 1 and 2 should b D. partment of Health and Ments Important: If item 27 Is marked any njury of other traumatic e or a.		Andrew Smolen / 20a. Method of Disposition	Legal	20b. P	lace of Dispo	sition (Name of		LTVET Date				ZU9U4 Town, State		
Baltimore,	Pages nent of int: If it		Donation 5 ☐ Other (Spe		State	•	natory`or other p				SS 2002-000	1000	1227025		
量	artme ortan injur		21. Signature of Funeral Service Li	-	ME	Olivet	Cemete 2. Name and Add	ry dress of Facilit	11/12/	2004 W	shing	gton,	D.G.		
B	Dermil		21. Signature of Funeral State Licensee  22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20												
	Priysician		23a. Part1. Enter the disease, or c shock, or leart failure. List or Immediate Cause (Final	nly one cause on	each line.	n. Do not ent	er the mode of o						Approximate Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)	a Cardiac Arrythmia  Due to (or as a consequence of):											
	Examiner		Conventinity list conditions	b. Cole	on Carci	noma									
	D ≅	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to											
	sician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last		emia Blo		S								
8760,	be ex cian curial	ai E			W-	derice or).									
387	physicate physicate	dicai		dDemo	entia										
.O. Box 6	it the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregna birth 2 Fetal gnant at time of de nown	death 3	Ectopic pregna Other (specify)					Date of delive Month	very Day Year		
Д	de de		Part II. Other significant condition	s contributing to	death but not resu	ulting in the u	nderlying cause	given in Part I		23e. Did toba	cco use co	ntribute to	the cause of death?		
ds	puires n sign	d by								1 ☐ Yes	2 XNo	3 ☐ Pro	bably 4 Unknown		
Records,	s been si s should t	Completed								24a. Was an	24b	. Were aut	lopsy findings available ompletion of cause of		
Be	The lav	mo								autopsy perform 1 Yes 2	ed?	death?			
Vital		a	25. Was case referred to medical	8 0				26. Place	of Death (C	heck only one			- <b>X</b>		
of V	S :5:	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2 🙀	ER/Outpatie	nt 3 DOA	Other: 4 Nu	rsing Home	5 🗆 Residen	ce 6 <u>□</u> 0	ther (Spec	ity)		
			27. Manner of Death 1 ★ Natural 5 Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time o Injury		njury at Vork?		. Describe hov	injury occ	urred			
Sio	Attending ir death. ector: After by the fune	catl	2 Accident investiga 3 Suicide 6 Could no	t he	and the transport of th			□Yes 2□		Location (Ctr	as and Mur	mhos os Du	sal Pauta Number		
Division	or Attendate death Director:	Certification:	4 Homicide determin	280. Plac	e of injury - At ho ding, etc. (Specif)	ome, tarm, st	reet, factory, onle	ce	201.	City or Town,		TIDER OF MUI	ral Route Number,		
_	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier Certifying	Physicien: To the	ne best of my kno	wledge, deat	h occurred at the	e time, date an	nd place, and	due to the car	ise(s) and i	manner as	stated.		
	e Hos 24 h e Fur letely	edical	29a. Certifier 29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Madicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause one)  and manner stated.												
	To the within 2 To the complet	29b. Signature and title of pertifier 29c. License number 29d. Date signed (Mont									ned (Month	n, Day, Year)			
	1		1	> Han	NIM.			D59284		No	vembe	er 10,	2004		
	$\wp$		30. Name and address of person w		use of death (Item 99 Lambe			lver S	pring,	-		20902			
	Sta	ate	31. Date filed (Month, Day, Year)	32.	Registrar's Signa		1								
•	Regist	rar	NOV 15 2	004 5	news	19	Spark	21							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** .45 Mae а 2004 Amie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne If Under 1 Year If Under 24 Hrs. 8. Date of Birth Arunde 1 Mollwood Menor Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Sex 1 □ M 2 X F **Funeral** Months Days Hours 99 → Yrs. 314-12-5523 Usual Residence of Decedent Director 10/20/1905 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is merked other than "natural", or items 23a or 28a-1 shov traumatic event, the Medical Examinar must be notified at 1 ☑Yes 2 ☐ No Anne Arundel 4D Funeral Director Millersville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A 21108 cecil Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRivate Residence Domestic Worker 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blake Ida harles Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/060 121 Faywood Court Apt. J Glen Burnie, MD. Cluff Ethel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/18/04 TRappe, MD. Paradise Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HENRY FUNERAL Home, P. A. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate **Physician** CEREBROVASCULAR DISEASE Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of Physiclan/Medical Examiner for Attending Physician: The law requires that the death certificate be executed after death.

Diractor: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit d in by the funeral director, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Diracto completely filled in by the 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D31136 my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBRIDE RD, BALTIMORES, MD 21236

Ms)

32. Registrar's Signature

NOV 1 6 2004 Fram It Spects

4005

CES

Registrar DHMH 16 Rev 6/95

State

BRIAN

31. Date filed (Month, Day, Year)

	1	For State Registrar		epartment of Health and Certificate of Death	Reg. No				
Physicia	an	1. Decedent's Name (First, Middle, Last)  \$\int LLA  \text{S}(n)	:Th		2. Date of Death Month Da	y Year OSOS			
/Medic Examin	er	4a. Facility Name (If not institution, give str ARGE NOR 5. Social Security Number 6. Sex	eet and number) S.J. Feluß 7. Age (In yrs. last birtho	4b. City, Town, or Location of Deat  SPUSBULY  If Under 1 Year I Under 24 Hrs  Months Days Hours Min.	8 Date of Birth	Country of Death  WiC.  9. Birthplace (State or Forei Country)			
Director		221-07-8609  Usual Residence of Decedent	M 2000F 94 Yrs	S. Months Days Hours Willia	(Month, Day, Year April 10, 1				
la-f show		10a. State 10b. County Maryland Wicomico	10c. City, Town o Salisbury	7	10.00	10d. Inside City Limi 1 ☐ Yes 2 ∑ N tizen of What Country?			
3a or 20 st be no	al Director	10e. Street and Number 8186 Jersey Road		10f. Zip Code 21801	10g. Cl	USA			
Mental Hygiene. arked other than "natural", or itema 23a or 28a-f show attc event, itte Medical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Amed Forces? 1 □ Yes 2 전 No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:</li> </ol>	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black			
ne. nen "natura nedical E	Completed I	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	Completed) (College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of wo fe. DD NOT use retired)	rking	and of Business/Industry			
Il Hygier other th	Be Cor	5th 17. Father's Name (First, Middle, Last)			me (First, Middle, Maide	mestic n Sumame)			
d Menta narked natic e	To E	Charlie  19a. Informant's Name/Relationship (Typ		lbrook Sallie  Mailing Address (Street and Number or R	ural Route Number, City	Hitch or Town, State, Zip Code)			
Department of Health and Mental Hygiene. Important: or Itema 23a or 28a-f show Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		Geraldine H. Jones/si  20a. Method of Disposition  1 \( \times \) Burial 2 \( \times \) Cremation 3 \( \times \) Re  4 \( \times \) Donation, 5 \( \times \) Other (Specify)  21. Signature F neral Service License	Date 20c. L 11/2004 Prin	altimore, MD 2122 ocation City or Town, State cess Anne, Maryla oad - Salisbury, M					
impol any ir once.		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations/that caused the/death. Do no	JOLLEY MEMORIAL		21801 Approximate			
nysician Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	A	WD		Iniérval Between Onset and Death 5 YLM			
death certificate be executed e attending physician and nd for use as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	Due to (or as a consequence of		N.				
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£ €	Physician/Me	IF FEMALE: 23  Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date ol delivery Month Day Year			
De De	by	Part II. Other significant conditions con	tributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death			
ate has been s page 2 should	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings avail prior to completion of cause death? 1 ☐ Yes 2 ☐ No			
this certificate	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No H	ospital: 1 ☐ Inpatient 2 ☐ ER/Outp	Othor	ath (Check only one) Home 5 Residence	6 ☐Other (Specify)			
death. octor: Atter by the tune	Certification:	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farr	ury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inj 28l. Location (Street a	and Number or Rural Route Number,			
4 hours afte Funeral Dir ety filled in	edical Cert	(Check only 2 Medical Examin	er: On the basis of examination and	death occurrad at the time, date and plac for investigation, in my opinion, death occ	e, and due to the cause(	s) and manner as stated.			
within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner stated.	29c. License number	Ne	ate signed (Month, Day, Year)			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  1415 5. Division St. SAUSBURY NO 21804 USha Natisan								

Control of Death   Control of		_1	For State Registrar	State of Maryland		rtment of H tificate of L		ientai Hyg	leg. No. 2 (	004	3801
4.4 Facility Name of Information of the street and number)  4.5 Special Security Number   2   5   5   5   5   5   5   5   5   5		ın	,	SM i	th						3. Time of Death
Use State and Number   100-City Town or Location   100-C				reet and number)					Wi		0
Top   State   Society	uneral irector		219-14-4237					8. Date of Birth (Month, Day 5 - 24-	( Xear) -25	9. Birthp Coun MD	ace (State or Fore try)
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Sequentially ist conditions and continuous of pregnancy and property of the state of grant of grant of the state of grant of g	a or 28a-1 1 be notifi		10e. Street and Number			10f. Zip Code			_	What Coun	try?
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19a Informants NameRelationship (Type, Print)   19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   19a Informants NameRelationship (Type, Print)   19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   20a Method of Disposition   20a Method of Disposit	then "natura ha Medical E	mpleted	(Specify only highest grade	completed)	(Give life. l	kind of work done of OO NOT use retired	ation furing most of work )	ing			dustry
23a Part Limer the disease, of complications that causing he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each vise.  ASCV.)  Spring and the control of the cause (Final death)  Sy YCMS  Spring and the control of the cause (Final death)  Be dependingly list conditions, if any, leading to mimodiate gause. Either Underlying is mimodiate. Ei	ked other ic event,	Be	· · · · · · · · · · · · · · · · · · ·					,		ıme)	
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Sea Part   Emer the disease, or complications that causing the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introductions and sealing in death)   Sy CWD	nent or rred ant: If item ary or othe		W☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State Sp.	lace of Dispo emetery, cren ringhi	sition (Name of natory or other plac 11 Mem. (	dns. 11/	10/04			wn, State
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FFEMALE:   23b; Was decedent pregnant in the past 12 mgnths?   1   1   ves   2   Mo   3   Probably 4   Pregnant at time of death   5   Other (specify)   23d. Date of delivery   Month   Day   Year   1   1   ves   2   Mo   3   Probably 4   Unknown   25b; Was case referred to medical examiner?   1   I   ves   2   Mo   3   Probably 4   Unknown   25c. Was case referred to medical examiner?   1   I   ves   2   Mo   3   Probably 4   Unknown   25c. Was case referred to medical examiner?   25c. Was case referred to medical examin	Medical aminer transit	licai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of the consequence of t	uence of):	45CVD					Onset and Deat
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Second   S	88	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.				
25. Was case referred to medical examiner?  1	2 5	Complete						autor perfo	med?	prior to co death?	mpletion of caus
DN 51359 November 10 1 2004	ith. : After this certific e funeral director.	To Be	examiner? 1 Yes 2 No  27. Manper of Death 1 Natural 5 Pending	1   Inpatient 2	28b. Time o	f 28c. Injur Wor	er: 412 Nursing H y at k?	ome 5 Resid	dence 6 🗆 C		y)
DN 51359 November 10 1 2004	s after dec al Director ad in by the	Certifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	reet, factory, office				nber or Rura	al Route Number,
DN 51359 November 10 1 2004	in 24 hour the Funeri pletely filk	edical	(Check only 2 Medical Examinate)	ner: On the basis of examina	wiedge, deat ition and/or in	vestigation, in my o	pinion, death occu	and due to the rred at the time,	date and plac	e, and due to	the cause(s)
	To 1	2		-11					-		-

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 38013 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 10:25 AM 11-09-2004 Saltelli /Medical Gaetano 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Princess Anne
| If Under 1 Year | If Under 24 Hrs. |
| Months | Days | Hours | Min. | 30529 Bardwell Drive Somerset Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 2M 2 F 65 01-17-1939 Director 217-58-3815 Greece Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or itams 23a or 28a-f show the Medical Examiner nest by notified at 1 Yes 2 No Director Somerset Princess Anne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Italy permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or ftame 23a ent injury or other treumatic event, the Medical Exemples install once. 21853 30529 Bardwell Drive Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married 1 Yes 2 No White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 none Salesman 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be Eduardo Saltelli Angela Iandalo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edward Saltelli/ Son 8218 Amethyst Drive, McLean, Va. 22102 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 11-12-2004 Salisbury, Maryland Salisbury Crematory 22. Name and Address of Facility
Hinman Funeral Home 21. Signature of Funeral Service Licenses M00295 J. 11673 Somerset Ave., Princess Anne, MD 21853 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final ease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes this certificate Division of Vital To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner?
1 X yes 2 □ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Watural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D 48098 11/11/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 201 Hall Highway, Crisfield, Md 21817 Vijay Karumbunathan, 32. Registrar's Signature State NOV 1 5 2004 Registrar

			ricas	State of Marylar				•	_	
			1 - For State Registrar	Otate of Marylar		tificate of Dea		Reg. N	2004	38014
		•	Decedent's Name (First, Middle,	Last)			2.	Date of Death	ay Year,	3. Time of Death
	Physici /Medi		taward 5	spicher				11 10	) 04	1119 AM
	Examir	ier	4a. Facility Name (If not institution,	Adulanty + H	120	4b. City, Town, or Locat	ion of Death	nd "	ic. County of Death MMtG8	NI OSLO
	Funeral		5. Social Security Number 6	Sex / 7. Age (In yrs.	last birthday)	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. 8.	Date of Birth (Month, Day, Yea	9 Perth	place (State of Foreign
	Director		18124-8790	10M 20F 72	Yrs.	Months Days Hou		et. 23,	1932 Penn	sylvania
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Qi	ty, Town or Lo	cation				10d. Inside City Limits
	Mary a-fsh	ctor	MI) Mont	gomery of	auth	uspurg				1 Nes 2□No
	or 28	Director	10e. Street and Number	1 4 5 //1001		10f. Zip Code		1	Citizen of What Cou	*
	ours after death with the Maryland ral', or Itams 23a or 28a-f show Examinat must be notified at	Funeral	9701 Fields Roa	ad Apt.#1801	J.S. 13. V	20878	c Origin? (Specify		nited Sta	
9	after d or Itan	Fun	1 □ Never Married 2 → Married	Armed Forces?		Vas Decedent of Hispanio Yes, specify Cuban, Mex Yes 2\hat{\text{No}} No Specify		an, etc.)	Black, White,	
Maryland 21215-0036	72 hours after "natural", or Ita olcal Examine	d by	3 Widowed 4 Divorced	Year or Dates:						ite
15	72 nai	Completed	15. Decedent's (Specify only highest	grade completed)	16a. Deced (Give	ent's Usual Occupation kind of work done during i OO NOT use retired)	most of working	16b.	Kind of Business/In	idustry
212		Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Teleph	one Consult	ant	Te	elephone	Company
nd	itd be filed lental Hygi rked othar tic evant, II	Be	17. Father's Name (First, Middle, La					irst, Middle, Maide	en Sumame)	
ryla	should nd Mer marke umatic	9	Charles Spiche		19b Mailin	g Address (Street and Nu	Esther I		or Town State Zin	a Code)
	d 2 a s		Gloria Spicher			Fields Road				, MD 20878
Baltimore,	permit. Pages 1 and Department of Heali Important: If itam 2 any injury or other page.		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3	1 ,	Place of Dispos cemetery, cren	sition (Name of natory or other place)	Nov.		Location - City or To	own, State
Ë	Pages tment of tant: If it jury or o		`4 □Donation 5 □ Other (Spe	city) Met	-	tan Cremato	ry 2004	Ale	xandria,	Virginia
Bai	permit. Departr importa any inji		21. Signature of Juneral Service Lie	ensee		Name and Address of Fa	DCVO	l Funera	1 Home burg, MD	20877
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	emplications that caused the deal					burg, in	Approximate Interval Between
J.	Pnysician		Immediate Cause (Final disease or condition	Con die	arre	- 4				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec		dies :	4		1	
		er	Sequentially list conditions,	b. Due to (or as a consec	quence of):	7 45702			1	
	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· Consista	12	art fail	W5			
760,	e be executed rsician and e burial-transit		resulting in death) Last	Due o or as a consec	quence of):	tu al	0.1	13820	0	
687	¥ × 9	edical		d. UNONIC V	2111011	1.05 PM	ON	11) (60		
Box (	eath certificat attending phy I for use as the	In/Me	IF FEMALE: 23b. Was d <i>ec</i> edent pregnant	23c. If yes, outcome of pregnant 1 Live birth 2 Feta		Ectopic pregnancy			23d. Date of delive	өгу
	at the deat by the attr tached for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of c		Other (specify)			Month	Day Year
P.0	de e		Part II. Other significant condition	s contributing to death but not res	sulting in the ur	iderlying cause given in P	Part I.	23e. Did tobacco	use contribute to t	he cause of death?
Records,	w requires been sign should be	ed by						1 🗆 Yes	2□No 3□Prob	bably 4 Unknown
eco	faw reas bee	Completed						24a. Was an autopsy		opsy findings available ompletion of cause of
E B		Соп						performed? 1□ Yes 2X N	death?	
Vital	Physiclan: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2	] ER/Outpatien	Othor	Place of Death (C.	200	6 ☐Other (Specif	6.3
οl	g Physter this	H	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		Describe how inj		у)
sior	Attanding or death. ector: After by the fune	catlo	1 Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion		M 1 Tyes 2				
Division	al or Attanding P s after death. at Director: After the	Certification;	4 Homicide determin		ome, farm, stre fy)	eet, factory, office	28f.	City or Town, Sta	and Number or Rura te)	al Route Number,
	To the Hospital or within 24 hours after To the Funaral Director Completely filled in b		29a. Certifier 1 Certifying	Physician: To the best of my kno	owledge, death	occurred at the time, date	e and place, and	due to the cause(	s) and manner as s	tated.
	the Ho in 24 the Fu	Medical	one)	and manner stated.	ation and/or inv					
	with To	~	29b. Signature and title of certifier	_		29c. License numb			ate signed (Month,	
7	Ψ		30. Name and address person wi	no completed care of death (Itel	m 23a) (Tvpe. I		3 3	Nov	ember 11,	2004
			Laurence R. Ke	elley, M.D. 790	01 Mapl	e Avenue Ta	akoma Pa	rk, Mary	land 2091	.2
	Sta Regist		31. Date filed ( <i>Month</i> , <i>Day</i> , <i>Year</i> ) <b>NOV 15</b> 20	32 Registrar's Signa	ature	Sporker				
	9.01	1 1	MOA TO CO	7-1	1	r				

		•	State of Maryland / Dep	artment of Health and Mertificate of Death		ene 9. Ko. 004	38015
	Dhysiai	200	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death
	Physici: /Medic		Shirley V. Smith		November		9:52 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
			Montgomery General Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	01ney ) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Montgome	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $173-24-5038$ 1 $\square$ M $2\cancel{\mathbb{N}}$ F 73 Yrs.	Months Days Hours Min.	(Month, Day,	1930 Penr	hplace (State or Foreign
			Usual Residence of Decedent		Dec. 17,	1550 1611.	isyivania
	yland		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	e-fs	cto	Maryland Montgomery Rockvil	.1e			1. Yes 2 □ No
	or 28	Directo	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?
	23e		16600 Summertree Court	20853		nited Stat	
	tems	Funeral		Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Wh	ite
Ş	hour ture!	q pa		edent's Usual Occupation	1	6b. Kind of Business/	Industry
5	in 72 "ne Fedic	Completed	(Specify only highest grade completed) (Giv.	e kind of work done during most of work. DO NOT use retired)	ing	oo. Kiild of Edomoda	mado, y
212	with iene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) 12 House	ewife		Own Home	
ᅙ	e filec of the of the	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M	laiden Surname)	
<u>a</u>	uld be Aenta rked tic ev	To E	William J. Voelker	Bertha M	ay Steel	e	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if item 27 is marked other than "neturel", or items 23e or 28e-1 show early injury au-other treumetic event, it is Madical Examiner must be notified at once.			ing Address (Street and Number or Rura			
Σ.	and salth			9 Pecan Grove Lane			
ore	of H		1 M Burial 2 Ucremation 3 Hemoval from State	ematory or other place) Nov.	Date 2	0c. Location - City or	Town, State
E	Pag ment ant: lury		'4 □Donation 5 □ Other (Specify)   Norbeck	Memorial Park 200	)4 0	lney, Mary	yland
391	ermit. epant nport ny in		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	22. Name and Address of Facility DeV			
	0 0 ₹ 0 0			O E. Deer Park Dr.			
H			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac of	or respiratory arres	St,	Approximate Interval Between Onset and Death
	Physician	6. 4	Immediate Cause (Final disease or condition resulting in death)  Pulmonary Embolis  a. Pulmonary Embolis	m			1 Day
	/Medical Examiner		Due to (or as a consequence of):				
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted 1 ansit	Examiner	cause. Enter Underlying				
<u>,</u>	exection and inal-tra	Еха	that initiated events c.  Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dlcal	d				
9	rtifica ng ph as th	Medi	IS SCHILLE.				
Вох	death certifications attending place as t	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deli	
О	e dea he at ned fo	sici	in the past 12 months?  1 Yes 2 No 9 Unknown 9 Unknown 5	Other (specify)		Month	Day Year
<u>Ч</u>	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as.	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underhing cause given in Part I	23a Did toba	acco use contribute to	the cause of death?
Ś	ires tha signed be dei	by	Breast Cancer	underlying cause given in r air i.			obabiy 4 □Unknown
20	w require been sig should b	Completed					
of Vital Records,	has l	шр	Diabetes Mellitus		24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of
a	n: Th licate r, pag		Hypertension		perform 1 Yes 2		2 No
₹	Physicien: rthis certificaral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 🖔 No Hospital: 1 🛣 Inpatient 2 ☐ ER/Outpatie	Other	n (Check only one		-16.1
ō	Phy r this ral di	.: To	1 ☐ Yes 2 ⚠ No	of 28c. Injury at	me 5 Hesider 28d. Describe hov		ciry)
On	th. : Afte	tior	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division	d or Attending after death. Director: After d in by the fune	ifice	3 ☐ Suicide 6 ☐ Could not be 28e, Place of Injury - At home, farm, s	treet, factory, office		eet and Number or Ru	ıral Route Number,
ā	s afte	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
	e Hospitel 24 hours a e Funerel l		29a. Certifier  (Check only 2   Medical Examiner: On the basis of examination and/or i				
	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	ledical	one) and manner stated.				
	To To To To To	Σ	29b. Signature and title of certifier	29c. License number		d. Date signed (Monti	
	12		Dr. Hilvie Hemz-Mounture	DU058542	^	100 11,	2304
_				01 Georgia Avenue	#515 W	heaton, MI	20902
	Sta Registi		31. Date filed (Month, Day, Year) NOV 15 2004 32. Registrar's Signature	Sparker			

			For State Registrar		State	of Ma	aryland		artment			and M	ental Hy	giene Reg. No	200	4	38016	5
	Physici		1. Decedent's Name (First, Midd	e, Last)									2. Date of De Month	aath Day	y Y	'ear	3. Time of Death	
	/Medic	al	Wilfred Martin 4a. Facility Name (If not institutio		-	umber)			4b. City,	Town, or	Location of		Novemb		0, 20 County of		7;43 M	
	£Xallill	eı	Montgomery Ger	iera]	L Hos	oita	1			Olr					Monto	qome	ry	
	Funeral		5. Social Security Number 317-26-5441	6. Sex 1 <b>√</b> □	M 2□F	7. Age	i (In yrs. la	ast birthday) Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept. 4	v. Year)		Birthp Cour Indi	place (State or Foreign ntry)	n
	Director		Usual Residence of Decedent										осрся	, 102				_
	ehow	70	10a. State 10b. County	!			10c. City	, Town or Lo	ocation							1	0d. Inside City Limits 1 ☐ Yes 2 📆 No	
	the M	rect	Maryland Mont	:gome	ery —		Burt	onsvi	11e 10f. Zip	Code				10g. Cit	izen of Wh	at Cour	ntry?	
	th with	al Di	6 Perrywood Co	urt					208	66				USA				
36	be filed within 72 hours efter death with the Maryland Ital Hyglene. ad other than "naturel", or Items 23a or 28a-f show event, I'te Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Mar  **Widowed 4 Divorced	ried	2. Was De Armed I 1. ∴ Yes If Yes, G Year or	Forces?			Was Deced If Yes, spec 1 ☐ Yes 2	rfy Cuba	spanic Ori n, Mexican Specify:	gin? (Spe 1, Puerto	cify Yes or No Rican, etc.)	0-	14. Race - Black, Specify:	Americ White,	etc.	
21215-0036	2 hou	ted t	15. Deceder (Specify only highe	nt's Educ	ation		Korea	16a. Dece	dent's Usua	Occupa	ation	t of worki	na	16b. K	ind of Busi			
215	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	si grade	College		+)		kind of wor DO NOT us				19					
	e filed within al Hyglene. I other than 'vent, I've we	e Coi	17. Father's Name (First, Middle,	Last)	4			Elec	trica	1_En			(First, Middle				rnment	
lan	2 should be to and Mental I is marked or raumatic eve	To B	Ivor Cecil Sim	ıpsor	1						E. Lo	rett	a Mart	in				
Maryland	2 sho		19a. Informant's Name/Relation:					19b. Maili	ng Address	(Street a	and Numbe	er or Rura	l Route Numb	er, City o	or Town, St	tate, Zip	Code)	
Baltimore, I	permit. Pages 1 and 2 should be Department of Health and Monla Importent: If Item 27 Is marked any injury of other traumatic and once	07.515	Jeffrey M. Sim  20a. Method of Disposition  1 Burial MCCremation				20b. Pl	6 Pe ace of Dispo emetery, crea	sition (Nan	ne of	e)		tonsvi ate 14		MD 2 ocation - C			
ij	rtment rtent: njury c		* 4 □ Donation 5 □ Other (\$21. Signature of Funeral Service	Specity)			Metr	ropoli	tan C		tory	2		Alex	andri	a,	Virginia	-
Ba	Depo Impo any		Will E				5	Fr	ancis	J.	Colli	ns E	uneral	Hom Silv	e, In	c.	g, MD 2090	01
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition	r complic t only on	e cause on	each lir	10.	. Do not en	ter the mod	e of dyin	g, such as						Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	a.			a consequ	ence of):	inta	rcti	or						Immediate	
	Lxammer	-	Sequentially list conditions,	b.	Val	vul o (or as	ar Ca	rdiom	yopat	h <del>y</del> —						-4	4 Years	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>5</b> .														
ő	sicien and burial-transit		resulting in death) Last		Due to	o (or as	a consequ	ence of):										
8760,	icate be exi physicien a s the burial	dicai		d.														_
Box 6	death certificate e attending phys id for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant	23	3c. If yes, c		of pregnar		⊒Ectopic pr						23d. Date		ary	
o.		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			gnant at	time of de		Other (sp					- II w	Month	h	Day Year	į
rds, P	law requires thet the as been signed by th 2 should be detache	þ	Part II. Other significant condit			death b	ut not resu	Ilting in the u	inderlying c	ause giv	en in Part I		1				he cause of death? pably 4 DUnknown	1
Records,	0 4 0	Completed											24a. Was auto perf		pride	or to co ath?	psy findings available mpletion of cause of	Э
Vital		a	25. Was case referred to medical	al							26. Place	of Death	1 Tes	one)	1 _	Yes	2 No	
of Vi	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Н		] Inpatie		ER/Outpatie		_	4 U NU		me 5□Res				iy)	
	After fune	tion:	27. Manner of Death  1 Natural 5 Pendi 2 Accident investi	ing tigation	28a. Dat (Mo	e of Inju onth, Da	ry y Year)	28b. Time of Injury	of 2	8c. Injun Worl	yat k? Yes 2. ☐		28d. Describe	how inju	ry occurred	d		
Division	iel or Attendi s efter death, al Director: A ad in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could	d not be mined			ury - At ho c. (Specify	me, farm, st	reet, factory	, office			28f. Location ( City or To			or Rura	al Route Number,	
	To the Hospital or within 24 hours efter To the Funeral Director completely filled in the Funeral C	edical (			er: On the		examinat						and due to the ed at the time,					
	To the I within 2: To the I complet	Me	29b. Signature and title of certific	er					290	. Licens	e number			29d. Da	te signed (	Month,	Day, Year)	
,	12		30. Name and address of person	) who are	moleted s	usc of a	loath /learn	23a) /Tun-	Print)	D00	35045			Nove	mber	11,	2004	
			Philip G. Hen							. #o	04 (	)]nev	, Mary	land	2083	12		
	St Regist	ate rar	31. Date filed (Month, Day, Year NOV 15	r)	32.	Registr	ar's Signat	ture		rks	-	<del>y</del>	, <u>y</u>					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Year **Physician** November Anna Holmes Steger 19, 2004 4:00 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Julia Manor Nursing Home Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1□M 2\ F March 23,1919 Kansas 85 Director 100-18-0787 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Departmant of Health end Mantal Hyglene. Important: if item 27 is marked other than "naturel", or items 23a or 28e-1 show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 14 Yes 2 □ No Director MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funerai 14. Race - American Indian, 2009 Rose Bank Way 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: \$ 3 N Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Samuel Holmes Helen Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Thomas H. Steger/Son 20a. Method of Disposition cemetery, crematory or other place) 2004 1 

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Bittinger Cemetery Nov. 21, Bittinger, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes, P.A. uma P.O. Box 275; Grantsville, MD23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical emen Examiner Due to (or as a consequence of): Physician/Medical Examiner HearT Cong est ive Hospital or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). ettending physician for use es the burial Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): 23b. DId tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Ves BLING 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this eral Director: After this filled in by the funerel 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 Yes 2 No death. 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide • Funeral 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Funel completely fi (Check only one) # 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 70060396 11119114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SERSTOWN, MD FARID MURSHE 1) MD 31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar

			For State Registrar		State of	f Marylaı			of Hea of De		Mental Hy	giene Reg. No.	U U 4	38019
			1. Decedent's Name	(First, Middle, La	st)						2. Date of D		-	3. Time of Death
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Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Fur			Cono	22	. Name and	d Address of	Facility <b>Fr</b> a	amptom	Fun	eral I	Home.P.A.
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	To the Hospital or Attending P within 24 hours after death. To the Funaral Director: After the completely filled in by the funera	Medical C	29a. Certifier (Check only one)	Certifying P	miner: On the ba	asis of examin	owledge, death ation and/or in	h occurred a vestigation,	at the time, d	ate and place n, death occur	and due to the	cause(s) date and	and manner as place, and due	stated. to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:40 A M TAYLOR NOV. 1Ó 2004 **FLORA** MAE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death **Examiner** SALISBURY WICOMICO COASTAL HOSPICE AT THE LAKE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖔 F Months 80 MARYLAND Director 219-14-4061 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County rai', or itama 23a or 28a-f ahow Executive transitie notified at 1X Yes 2 No Directo WICOMICO WILLARDS MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7327 CANAL STREET 21871 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced "netural", Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than SCHOOL CAFETERIA MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked RUFUS LITTLETON MAUDE т. 2 permit. Pages 1 and 2 should Department of Health and Milmportent: If Item 27 is mantany injury or other traumattones. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7328 DIVISION ST., WILLARDS, MARYLAND 21874 JUDY T. SMACK/DAUGHTER 20a. Method of Disposition
1 ঐBunal 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State NEW HOPE CEMETERY 11/13/04 WILLARDS, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility abuette HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ne do resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes No 23d. Date of delivery 3 Ectopic pregnancy ō Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed þ pe 1 Yes 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? was autopsy performed? certificate has 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient ٩ 2 ER/Outpatient 3□ DOA 1 Tes this 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation Natural death. М 1 Tes 2 No 2 ☐ Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral 6 Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner\_elated\_ (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra 38022 Certificate of Death Reg. No: 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 9:15 Mildred A.M Virginia Tichinel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ) M be RLA n ir 1 Year | If Under 24 Hrs. CART GAN Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Days Min. Hours 1 □ M 2 🖸 F Yrs Director 215 82 3640 Usual Residence of Decedent Barnum, WV Aug 22 1913 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, if a Medic-Exert in at must be retified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2½ No Director MD Garrett Swanton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3605 Walnut Bottom Rd. 21561 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oris Warnick Maggie Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joe Tichinel 2668 Walnut Bottom Rd Swanton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery Nov26 2004 Mt. Zion, MD Mt. 21. Signature of Funeral Service License 22. Name and Address of Facility David A. Burdock Funeral Home ndock 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause of peach line. St. Kitzmiller, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day detached for 4 Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Natural 5 | Pending 1 ☐ Yes 2 ☐ No 2/ Accident investigation completely filled in by the Diractor: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours after To the Funaral Dira 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Sxeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manper stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23 ) (Type, Print) 21562 90 Main Street WESTERN PORT, MD DR Shin Kim 31. Date filed (Month Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Charles Roland Tyler November 6, 2004 6:35 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health Care of North Arundel Glen Burnie Anne Arundel 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 71 212-30-2883 Director August 7, 1933 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral, or itams 23a or 28e-f ehow Evantors outst be notified at 1.□Yes 2□No Maryland Anne Arundel Glen Burnie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 North Crain Highway # 902 21061 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. and if item 27 is marked other than "natural; or ite any or other traumatic event, item Medical Eventions by or other traumatic event, item Medical Eventions. I ☐ Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: Black If Yes, Give Year or Dates: à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Roland Tyler Pauline Hughes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfreda Tyler/ Daughter 11221 A Avalanche Way, Columbia ,MD 21044 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 7 permit. Pages 1 Department of H Important: If ite any injury or ot ance. 1 ☐ Burial ② Cremation 3 ☐ Removal from State West Arundel Crematory 2004 Odenton, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, P.O. Box 58007 Washington, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) scardial **Physician** /Medical Due to (or as a consequence of): 6 **Examiner** Corons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ solling 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 Yes 2 No the Hospitel or Attending Physician: Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner? Other: 45 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outnatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury 1 Matural 5 Pending 1 Tes 2 No 2 Accident investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 15 504-E November 6, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 Hospital Brive Suite 208 OctiAnEJ 31. Date filed (Month, Day, Year) 32. gistrar's Signature State (parti) NOV 1 0 2004 Registrar

Jacon Bara

ORIGINAL

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		1 - For Stata Registrar			tificate of			**************************************	38025
Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of Death	100	3. Time of Death
/Med	ical	Mary 4a. Facility Name (If not institution, give s		Tower		es I continue of Dec		r 12,2004	6:00 A M
Exami	ner	Dorchester General			Cambr	or Location of Dea	ıtn	4c. County of Dear	
Funera		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hr.			hplace (State or Foreign untry)
Director		220-26-2298 Usual Residence of Decedent	75	Yrs.			June 28	,1929 Mar	yland
yland how		10a. State 10b. County	chester 10c. City	, Town or Lo	cation				10d. Inside City Limits
Z am am	Director	Maryland	L L	inkwoo	1				1 ☐ Yes XXNo
hours after death with the Maryland hours; or Itams 23a or 28a-f show all Examinat must be notitied at	D N	10e. Street and Number 5321 Linkwood Road			10f. Zip Code	835	10	g. Citizen of What Co	untry?
death death	nera		Was Decedent Ever in U.S Armed Forces?	6. 13. V			Specify Yes or No- to Rican, etc.)	US 14. Race - Ame	
s after or Its	y Fu	1 Never Married 2 Married	1 □Yes XXNo If Yes, Give		☐ Yes XX No		to Hican, etc.)	Black, White	<sub>e, etc.</sub> White
ING 21215-UU36  be filed within 72 hours after death with the Marylan tal Hygiene. d other then "natural", or itams 23e or 28e-f show avant, the Medical Exeminer must be notified at	Completed by Funeral	XXWidowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	16a, Deced	ent's Usual Occup	pation	1	6b. Kind of Business/	
within 72 ene.	) plet	(Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	kind of work done OO NOT use retire	during most of wo d)	orking	oo. Kind of Dusiness	industry
d 21 filed wi Hygien other th	Co	10		Caf	eteria W			Food Ser	vice
	o Be	17. Father's Name (First, Middle, Last)  Charles Raymond	Coates				me (First, Middle, M		
re, Maryld s 1 and 2 should f Health and Mer itam 27 is marke other traumatic	2	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street		Christoph ural Route Number,	City or Town, State, 2	ip Code)
and 2 ealth a n 27 i	1	Freddie R. Towers	Son	412	Aurora S	treet Ca	mbridge, 1	Maryland 2	1613
O º º = =		20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	metery, cren	sition (Name of natory or other place	· 1 .		Oc. Location - City or	
<b>Baltimor</b> permit. Pages Department of Important: If it any injury or o		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral → Ioth License		22	ans Ceme	es of Facility		Hurlock,	
Deg man		I file I lom	_	T	homas Fu	neral Ho	me, P.A.	e, Marylan	3 21 (12
		23a. Part. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death.	. Do not ente	or the mode of dyin	ng, such as cardia	c or respiratory arres	e, Marytari	Approximate Interval Between
Priysician		Immediate Cause (Final disease or condition resulting in death)	Cardio	muc	peath	4			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequent	ence of):	1	J			1.300
	je.	Sequentially list conditions, if any, leading to immediate cause. Fits the darlying	Due to (or as a consequent	ence of):					
ou, ba exacuted ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
	calE		Due to (or as a conseque	ence of):					
OX 68/6U, certificate ba ex rding physician use as the buria	ed	d.							
hat the death certificated by the attending phetached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o		Ectopic pregnancy	,		23d. Date of deli	•
be death the the attent ched for u	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□ Unknown		Other (specify)			Month	Day Year
	by Ph	Part II. Other significant conditions conf	ributing to death but not resul	ting in the un	derlying cause giv	en in Part I.	23e. Did tobe	cco use contribute to	the cause of death?
requires wrequires been sign should be							1 ☐ Yes	2 No 3 □ Pro	bably 4 □Unknown
S 0	ompleted						24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
Th Th	e Cor	OF Man area enforced to modified						d? death? No 1 ☐ Yes	24 No
Of VICA Physiclan: this certific ral director,	0 B	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1 <b>X</b> Inpatient 2 ☐ E	R/Outpatient	3□ DOA Oth		ath Check on one)	ce 6 ☐Other (Speci	6.1
ng Ph ng Ph fter th	D: T	27. Manner of Death 1 Natural 5 ☐ Pending		28b. Time of Injury	28c. Injun Worl	y at	28d. Describe how		(97)
Attending sr death. •ctor: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No			
after after Direct Dire	ertiflcation:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28t. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
To the Hospital or Attendit within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	edical C	29a. Certifier  (Check only 2 Medical Examin	cian: To the best of my know	ledge, death	occurred at the tim	ne, date and place	, and due to the cau	se(s) and manner as	stated.
the H thin 24 tha F mplete	Medi	29b. Signature and title of certifier	er: On the basis of examination and manner stated.	n and/or invi					
Viii Viii Viii		1 1 1 Doom	That		29c. License	3228		Date signed (Month,	
		30. Name and address of person who cop	pleted cause of death (Item 2	23a) (Typ <b>97</b> P	rint)	0-00		NO VOILE	r IZIZOUY
		willam f	7air 101		rampl	e DE	Campr	idge 1	11 21613
Sta Regist	ate rar	31. Date filed (Month, Day Year) 1 6	2004 Signatu	#	South			. 1	

1. December Name (First Motion, Last)				1 - For State Registrar	State of Mary	land / Depa	artment o	of Health and of Death		giene eg. No.200	4 3802	6
Second Security Number   Sec		/Media	al	Alice Faye VINSON	1		4. Ch. T.		2. Date of Dea Month	Day 11 20	3. Time of Death	u .
28   Feb. 19   100   1			ier	Washington County	Hospital	ı vrs. last birthdav)	Hage	rstown		Wash	ington	
Mack Dowell Richards  Jocie Emmajean Guilliams  Jocie Great Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Great Guilliams  Jocie Great Guilliams  Jocie Great Guilliams  Jocie Guilliams  Jocie Guilliams  Jocie Emmajean Guilliams  Jocie		Director		218-62-8005 Usuel Residence of Decedent	M 25XF	53 Yrs.	Months D		in. (Month, Day	, Year)	Country) Virginia	111
Mack Dowell Richards  Jocie Emmajean Guilliams  Jocie Great Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Great Guilliams  Jocie Great Guilliams  Jocie Great Guilliams  Jocie Guilliams  Jocie Guilliams  Jocie Emmajean Guilliams  Jocie		the Marylan 28a-f show wiffied st	ector	Maryland Washing			own				10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
Mack Dowell Richards  Jocie Emmajean Guilliams  Jocie Great Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Great Guilliams  Jocie Great Guilliams  Jocie Great Guilliams  Jocie Guilliams  Jocie Guilliams  Jocie Emmajean Guilliams  Jocie		Marth 13e of					TOT. ZIP CO		1		it Country?	
Mack Dowell Richards  Jocie Emmajean Guilliams  Jocie Great Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Great Guilliams  Jocie Great Guilliams  Jocie Great Guilliams  Jocie Guilliams  Jocie Guilliams  Jocie Emmajean Guilliams  Jocie	9800	ours after deal	by	1 ☐ Never Married 2 📉 Married	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give				(Specify Yes or No- erto Rican, etc.)	Black, \	White, etc.	
Mack Dowell Richards  Jocie Emmajean Guilliams  Jocie Great Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Emmajean Guilliams  Jocie Great Guilliams  Jocie Great Guilliams  Jocie Great Guilliams  Jocie Guilliams  Jocie Guilliams  Jocie Emmajean Guilliams  Jocie	21215-(	within 72 h iene. r than "netu	omplete	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work de DO NOT use re	one during most of	working			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate Intrineval Between Operation of the Course of the Cour	nd	be filectal Hyg			_			18. Mother's N	Name (First, Middle, A			_
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate Intrineval Between Operation of the Course of the Cour	ryla	hould to Meni	2		-01	105 14-11						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate Intrineval Between Operation of the Course of the Cour		nd 2 slath an 27 le r										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate Intrineval Between Operation of the Course of the Cour	imore,	Pages 1 annent of Hex ant: If item ury or othe		1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State	0b. Place of Dispo	sition (Name o	of place)	Date	20c. Location - City	or Town, State	
Try sicial mediate Cause (Final disease or condition resulting in death)    Try sicial mediate Cause (Final disease or condition resulting in death)	Balt Balt	permit. Departi		) Tool!	MMun	und 4	15 E.Wi	lson Blvd	l., Hagerst	town, Md.		
That initiated events resulting in death) Last resulting in death last resulting in death) Last resulting in death) Last resulting in death last resulti		/Medical	L.	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con	sequence y:	er the mode of	dying, such as card	facelie	est,	Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	88760,	icate be executed physician and s the burial-transit	dical	that initiated events								
25. Was case referred to medical examiner?  1	. Box	the death certify the attending iched for use a:	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 2□ 4□Pregnant at time	Fetal death 3						
25. Was case referred to medical examiner?  1	rds, P	equires that en signed b	ed by Pt	Part II. Other significant conditions cont	tributing to death but not	t resulting in the un	derlying cause	given in Part I.				
The street of th									- autopsy perform	prior death	to completion of cause of 17	
27. Manner of Death   Natural   Suicide   Accident   Suicide   Accident   Suicide   Accident   Acci		yslcie is certi directo	0 0	examiner?	ospital:	2 ER/Outpatient	3 □ DOA	Other			inació d	
Solution of the determined street and Number or Rural Route Number, State)    Solution of the determined street and Number or Rural Route Number, State	o uois	ending Ph sath. or: After th he funeral		1 Natural 5 Pending investigation	28a. Date of Injury	28b. Time of	28c. li	njury at Work?			рөспу)	
	DIX	itel or Atters after de rel Directo			28e. Place of Injury - building, etc. (Sp	At home, farm, stre	et, factory, offi	се	28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,	
29a. Certiflier (Check only one)		To the Hospitel or within 24 hours after To the Funerel Dir. completely filled in It.	edical	(Oriock only 2 Medicel Examin	er: On the basis of exar	knowledge, death mination and/or inv	occurred at the estigation, in m	e time, date and pla ny opinion, death oc	ce, and due to the cau curred at the time, dat	use(s) and manner te and place, and c	as stated. due to the cause(s)	_
		28	Me	29b. Signature and title of certifier	<i>M</i>					d. Date signed (Mo	onth, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A Musheret 21 Wyand Dy Kerkyrville MJ 21756	(			30. Name and address of person who con			Print)	. (, , , ,	7	2/20	/	
State 31. Date filed (Month, Day, Yeár) 32. Pegistrar's Signature  Registrar  NOV 1 8 2004					32 Pegistrar's S		Ke	rysvell	L MJ "	-1/36		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38027 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day MILDRED ANN WILLIAMS 3:05 A M NOV. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BERLIN NURSING & REHAB CENTER WORCESTER BERLIN If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 71 Director 416-44-3034 ALABAMA SEPT. 10, 1933 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir then "neturel", or items 23e or 28e-f ehow the Medical Examinational be notified at 1 Yes 2 □ No Directo MARYLAND WORCESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #14 144TH ST., APT. 103 21842 filed within 72 hours after death 1 Hygiene. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PREP CHEF permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: If item 27 Is marked other tr any injury or other treumatic event, the ODG. RESTAURANT 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be VITO THOMAS VETRESS TIDWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON STEWART HYDAR/STEPDAUGHTER 5348 SUNSHINE DR., ST. LOUIS, MO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 □ Burial 2 X Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 11/10/04 DELMAR, DELAWARE 21. Signature Fineral Service Licens 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part Enter the disease, or complications that append the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician TAFS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy ed by the atter Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy performed? (es 2010 certificate 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 3 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this ierel Director: After th 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6

31. Date filed (Month. NOV 1 2 2004 State Registrar

Molas

odula 32. Registrar's Signature

Heted cause of death (Item 23a) (Type, Print)

		4		Please Type or Print in Black Indelik	ole ink. Ensure Al	I Copies Ar	e Legible.	
		7		State of Maryland / Departme	ent of Health and M	fental Hygier	ne a a :	
				For	ate of Death	Reg. i		38028
				1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
_		Physici		Elistah Williams			Day Year ろi わ4	0125 AM
		/Medio			City, Town, or Location of Death		4c. County of Death	0.7
	1	Examin	ıer	tar v domity v tarret v	CAMBRIDGE		DORCHE	STER
		Funeral		5. Social Security Number 6. Sex / 7. Age (In yrs. last birthday) If Un	nder 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea		place (State or Foreign
		Director		248-60-3810 18M 20F 67 Yrs. Mont	ths Days Hours Min.	July 26	1937 500	The Careling
				Usuel Residence of Decedent		25.759		771
0	1	ylanı		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
7	\$	Ma-1-s	ş	MD Dorchester Cambri	idge			1  Yes 2  No
50>	X	n the	ire	10e. Street and Number 10f.	. Zip Code	10g.	Citizen of What Cou	ntry?
Ó	3	ith with the Marylar 23s or 28s-f show ust be notified at	Funeral Director	520 Glenburn Avenue	21613		USA	
	6	er death w Items 23a	ner	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was De	ecedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	can Indian,
	9	after or Ite	교	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	s 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: A	
ELIJAH	21215-0036	n 72 hours after dea "natural", or Items	1 by	3 Widowed 4 Divorced Year or Dates:			61	ack
7	5-0	72 hours 'natural',	etec	15. Decedent's Education 16a. Decedent's L (Specify only highest grade completed) (Give kind of	f work done during most of work	ing 16b	. Kind of Business/In	dustry
T	21	within ene. than "	ig.	Elementary/Secondary (0-12) College (1-4or 5+)	T use retired)	4	Rehab	Center
th			Completed	6 ASSEMI		Ker		
-	and	be filec Ital Hyg od othe event,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	en Sumame)	
11	<u>ya</u>	should be ind Menta i marked umatic ev	2	Jerome Williams	Ophe	lia Di	r:995	
3	Maryl	and and is m	1	14	iress (Street and Number or Rura	al Route Number, Cit	ty or Town, State, Zip	
WILLIAM	2	and ealth n 27 rer tr		Moses Williams Sisph	11:05 ST, CO	imbridg	e, Mary 10	wd 21613
二	altimore,	00-		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	or other place)	4.4	. Location - City or To	_
E	Ě	permit Pag Department Importent: f any injury o		4 □Donation 5 □Other (Specify) Defiel (10	Metery 11-1	12-04 C	ambridg	e, MD.
>	a	permit Pag Department Important: I any injury c	1	21. Signature of Funeral Service Licensee	e and Address of Facility RY FUNERCE	I HOME,	C.A.	,
	Ω	89 5 2 9		Kindle C. Sewax 510	1 Wash Wate	NOSTICO	Mbri da	,MD.21613
				23a. Part / Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arrest,	9	Approximate Interval Between
	NII.	Physician		Immediate Cause (Final disease or condition				Onset and Death
	4	/Medical	ŀ	resulting in death)  Due to (or as a consequence of):			· · · · · · · · /	2 1900
4	-	Examiner		aspiration	-appral	_	Je de la company	2 hours
			jer	caqueritially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	0			2 hours
		be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. Cultural Cause (Disease or injury that initiated events c.	exect		1	Thours
	ď	be execut ician and burial-trar	Exa	resulting in death) Last Due to (or as a consequence of):			1	
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	Division of Vital Records, P.O. Box 687	leath certificate t attending physic I for use as the b	Physician/Medic					
	ŏ	ndin use	2	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopi	·		23d. Date of deliv	ery
	Ď	death a atte d for	cia	in the past 12 months?  1 Vec 3 No.  4 Pregnant at time of death 5 Other	r (specify)		Month	Day Year
	0	at the de by the a	hys	9 Unknown				
	<u> </u>	res that igned to be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tobaco	co use contribute to t	he cause of death?
	rds	quire n sig ald bu	D 0	pliabelles.		1 ☐ Yes	2d No 3 Prot	oably 4 Unknown
	Ö	w require been sig	Completed	Miples asclaration des	elar o	24a. Was an	24b. Were auto	psy findings available mpletion of cause of
	Re	ne la e has ge 2	Ę	you and the same of the same o		autopsy performed	? 🚽 death?	
	a	n: Th licate r. pa		OF Western day medical	20 Di 1/2	1 Yes 2	No 1 □ Yes	21-170
	Κ	ding Physician: The law h. After this certificate has b funeral director, page 2 s	o Be	25. Was case referred to medical examiner?  Hospital:	Other	h (Check only one)	S 00th (S	5.1
	of	Phys this ral di	-	Tell res 2010 Enpatient 20 ENOutpatient 30	J DOA 4 Nursing Ho	me 5 Residence		y)
	-C	ding h. Afte fune	ion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No			
	S	deat deat stor:	ca	3 Suicide 6 Could not be age Place of Injury. At home form street for		28f. Location (Street	and Number or Run	al Route Number.
	≥	I or Attendi after death. Director: A I in by the fu	Certification;	4 Homicide determined building, etc. (Specify)	,	City or Town, St	tate)	
	_	pital ours eral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	rred at the time, date and place.	and due to the cause	a(s) and manner as s	tated.
8		To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical Exeminar: On the basis of examination and/or investiga one)				
		o the	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
		⊢ \$ ⊢ ŏ		Da hara No	14005997	3 101	131/01	
				30. Name and address of person who completed cause of death (Item 23a) (Type Print)			-11-7	
				Darvicia A Johnson 100 Br	somble St	Cambr	del m	021613
		C+	ate	31. Date filed (Month, Day, Year) 32. Relistrar's Signature		C C C C C C C C C C C C C C C C C C C	7	
Sc.		St Regist		NOV 1 6 2004 France 18 Proces	le)			

Amend #8 per FD ACcenty Health Dept. 11/12/04 10 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Reg. 16. 00 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ALBERT Month **Physician** WILLIAMS 09 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Catherine's Nursing Center Emmitsburg If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months 99 Director 312-24-5496 9 Ohio Usual Residence of Decedent the Maryland \*how 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No Directo Charles Maryland LaPlata 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9535 May Day Street 20646 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. D.C. School Elementary/Secondary (0-12) College (1-4or 5+) 12th 4 yrs. Educator System other 1 of Health and Mental Hygitem 27 Is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Robert H. Williams Carrie Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 608 Waldorf, Md. 20604 Erlene Williams (Daughter) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō = 5 ₩ Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Woodside Cemetery 11/16/04 Oxford, Ohio \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, Lavy & Rean M60483 West St. Annapolis, 821 Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Treo gressimp Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physicien and for use as the burlal-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ģ s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy perform Division of Vital 2 2 1 ☐ Yes 2 ☐ No funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Tursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending After 1 Natural 5 Pending death. after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled i Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of pertitier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of son who completed cause of death (Item 23a) (Type, Print) 30 212, egistrar's Signature 31. Date filed (Mont State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene

			otato of Maryland	Certificate o		, ,	eg. No?	1. 20020
			1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month		3. Time objects
	Physici /Medio		LORETTA MAY YOUNG			11	14 200	
	Examir		4a Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	cetion of Death	4c. County of I	Death
			Williamsport Retirement Village		Williams		Washin	-
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	Months Day		<ol><li>Date of Birth (Month, Day,</li></ol>	Year) 9.	Birthplace (State or Foreign Country)
	Director		535-44-9323 8/	Yrs.		4/10/19	17 C	alifornia
	and *		Usual Residence of Decedent           10a. State         10b. County         10c. City,	Town or Location				10d. Inside City Limits
	laryla sho	ō		ppensburg				1 ☐ Yes 2 ☐XNo
	the N	ect.	10e. Street end Number	10f. Zip Code	1	1	0g. Citizen of Wha	t Country?
	tar death with the Marylar thems 23a or 28a-f show instribut be notified at	ā	602 Baltimore Road		7257		USA	. ood.my
	eath ms 23	era	11. Marital Status 12. Was Decedent Ever in U.S.			cify Yes or No-		American Indian,
20	g 2 B	by Funeral Director	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, specify Co	f Hispanic Origin? (Spe uban, Mexican, Puerto o <i>Specify:</i>	Rican, etc.)	Black, V Specify:	White, etc. White
Baltimore, Maryland 21215-0020	n 72 hours natural',	8	**	16a. Decedent's Usual Occ	unation		16b. Kind of Busin	ess/Industry
5	in 72	Completed	(Specify only highest grade completed)	(Give kind of work dor life. DO NOT use reti	e during most of working)	ng	TOD. PAING OF EGOIN	ossinadony
72	withir than	E	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	,		Home	
B	be filed withir ntal Hygiene. Id other than evant, the Me		17. Father's Name (First, Middle, Lest)		18. Mother's Name	(First, Middle, M	Maiden Surname)	
au	uld be fill Mental Hi rkad oth	To Be	George Marriott		Hanna	Sena De	eHart	
ar <sub>y</sub>	d 2 should th and Mer 7 is marks traumatic		19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Stre	et and Number or Rura	l Route Number	City or Town, Ste	te, Zip Code)
Š	od 2 11h a 27 is r trat	ĺ	Judy K. Fogelsonger/Daughter	602 Baltimor	e Road, Sh	ippensbu	irg, PA	17257
ē,	iges 1 an it of Heal if itam 2 or other	1	20a. Method of Disposition 20b. Place	oe of Disposition (Name of netery, crematory or other p	(aca)	Date :	20c. Location · City	or Town, State
ê E	Pages nert of int: if its iry or o		1 D Burial 2 Dicremation 3 D Removal from State	thsburg Crem		1/15/04	Smithsbu	irg. MD
₫	글 투원를 .	- 1	21. Signature of Funeral Service Licensee Mo1414	1		_	Funeral	
ã	Depa impo any is	- I	1001717		J.			
			23a Part 1 Early the disease or complications that caused the death		dbury Aven		-	Approximate
i	Dhuaisian	9	23a. Part1 Enter the disease, or complications that caused the death.	DO NOT CITIES THE WOOD OF C	ying, odon do odnotdo c	r roopiiaiory arre	,,,,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final	5- ((FA)	TALL	_		7
	Examiner		resulting in death)	JE HEART	PAILUI	CC		CMONTHS
		ē	Due to (or a	s a consequence of):				
	uted d ansit	edical Examiner	b	s a consequence of):				1
ć	law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for usa as the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0 u 00.1100 quo.1100 0.7.				I I
68760,	/sicia	cal	that initiated events	s a consequence of):				
89	g phy as th	Med	resulting in death) Last					
Box	andin usa	5	d		==.			
œ.	death e atte	Sician	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause	given in Part I.	23b. Did to	bacco use contrib	oute to the cause of death?
P.0.	t tha by th tache	h	Caral and the American					Probably 4 Unknown
Ġ.	s tha	Ş	Cerebrovascular DisEASE					
of Vital Records,	v requires that tha death cer been signed by the attendir should be detached for usa	Completed by Physician/	VASCULAR Dementia.			24a. Was ar		4b. Were autopsy findings available prior to
ပ္ထ	s bed	plet	MARCION BEMENTIS			pononi		completion of cause of death?
æ	The law ate has page 2	E				1□Ye	s 212No	1 ☐ Yes 2 ☐ No
ta	an: 1 tifica tor, p	Bec	25. Was case referred to medical		26. Place of Death	(Check only on	9)	
≥ ;	Physician: rthis certific ral director,	To B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 EF	VOutpatient 3 DOA	Wh		nce 6 Other (5	Specify)
0	a Phy er thi	=	27. Manner of Death 28a. Date of Injury 28	Bb. Time of 28c. In			w injury occurred	.,,,
ਠ	Attending ir death. actor: After by tha fune	윭	1 1 1 2 Natural 5 □ Pending (Month, Dey Year) 2 □ Accident investigation		Yes 2□No			
	Atte ar de by th	E E	3 ☐ Suicide 4 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, offic	9 2	28f. Location (Sti City or Town		r Rural Route Number,
0	s after sin Dir	Certification:	building, etc. (Specify)			ony or roun	, otato)	
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of exemination and manner stated.	edge, death occurred at the n and/or investigation, in my	time, date end place, e opinion, death occurre	and due to the ca ad at the time, da	use(s) and manne ite and place, and	r as stated. due to the cause(s)
	ithin o the	M	29b. Signature and title of certifier	29c. Lice	nse number	29	d. Date signed (M	fonth, Day, Year)
			160VOUD NOT	2.4	3700		lovember	
	1-10	-	30. Name and address of person who completed a visual firm		,,,,,	-	O CONTINUE	14, 2004
5	4-10		30. Name and address of person who completed ceuse of death (Item 2:	3a) (Type, Print)	WILLIAMS	PAGE T A	N 71.	705
	Sta	10	31 Date filed (Months Deu Year)	CITY	V-11/1/201.00	UKI (I	11 61	110
	Sta Registr	ar	NUV 1 7 2004	4. Ang. V.				

DHMH 16 Rav 6/95

			1 - For Amend Items	23a,29b,c,30 22 per FH	per bi Ce	rtificate of l	<b>2/02/04dM</b> Death	ental Hyg	ie2e001	38031			
			1. Decedent's Name (First, Middle, Last					2. Date of Deat Month	h	3. Time of Death			
1	Physici: /Medic		Jeanne Ellen Ash	erman				11	16 2	004 6:45pm M			
	Examin		4a. Facility Name (If not institution, give	street and number)			Location of Death		4c. County of				
			9015 Walden RD.	x 7. Age (In yrs.	la et hiethelass		pring, MD	<ul> <li>20901</li> <li>B. Date of Birth</li> </ul>		mery Birthplace (State or Foreign			
	Funeral Director		5. Social Security Number 6. Se	х Эм 2 <del>Д</del> F 52	Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	Country)			
			128-38-4489 Usual Residence of Decedent	12 32				6-24-	1932 11	ew York			
	yland		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits			
	e Ma	cto	MD. Montgom	ery S	ilver	Spring				1 ∑Yes 2 □ No			
	or 28	Director	10e. Street and Number	•		10f. Zip Code		1	0g. Citizen of Wha	at Country?			
	ath w	ra	9015 Walden Road			2090			USA	American Indian,			
336	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "naturel", or items 23e or 28e-f show event, in Medical Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates:		was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Spec in, Mexican, Puerto F Specify:	ican, etc.)	Black,	White, etc. white			
Š	2 hou	ted	15. Decedent's Edu	ication		dent's Usual Occup			16b. Kind of Busin	ness/Industry			
21215-0036	within 72 ene. than "nai	ple	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use retired	during most of working	9					
	e filed within al Hygiene. I other than vent, the Me	Completed		+5	Att	orney				Practice			
Maryland	2 should be fill and Mental H. Is marked oth reumetic even	To Be	17. Father's Name (First, Middle, Last) Robert Asherman				18. Mother's Name Enid I		Maiden Sumame)				
ary	s 1 and 2 should f Health and Men item 27 Is marke other treumetic		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address (Street a	and Number or Rural	Route Number	, City or Town, St	ate, Zip Code)			
	0 =		Gilberto Jusino	(husband)	9015		Rd. Silve		•				
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 [X]Cremation 3 ☐ [	1 ,	Place of Dispo cemetery, cre-	osition (Name of matory or other plac	ce) Da	ite	20c. Location - Ci	ty or Town, State			
Ē	Pag ment lent: I		* 4 □ Donation 5 □ Other (Specify)	Che		e Cremato		2/04	Beltsvil	le, MD			
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service Licen	Ifollar	1	2. Name and Addres 33 Gist A	ss of Facility <b>Rap</b> ve. Silve	p <b>Funer</b> Sprin	ral and (g MD. 20	Cremation 901 Services			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deal	th. Do not en	ter the mode of dyin	g, such as cardiac or	respiratory arre	est,	Approximate Interval Between			
	Physician		Immediate Cause (Final	disease or condition Pospiratory Failure									
	/Medical		resulting in death)	Due to (or as a consec	uence of):	Luc							
в	Examiner		Sequentially list conditions,	b. Breast Can									
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_	rcate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c.  Due to (or as a consec	uence of):								
8760,	be e	al											
687		edical		0.									
O. Box	uires that the death certific signed by the attending p Id be detached for use as i	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 24☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	,			
О,	The law requires that the site has been signed by th bage 2 should be detache	by Pt	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribu	ute to the cause of death?			
rds	w require been sig should b		,					1 □ Ye	es XI□No 31	☐ Probably 4 ☐Unknown			
Records,	aw requ is been 2 should	Completed						24a. Was a	n 24b. We	re autopsy findings available			
Re	The lay	E O						autops perform	ned? dea	r to completion of cause of th? I Yes 2 □ No			
Vital	icien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death		71				
of V	S S	To	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing Hom	e 5 X Reside	ence 6 Other	(Specify)			
		on:	27. Manner of Death  1 → Natural 5 → Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Worl		3d. Describe ho	w injury occurred				
Sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	00 84 (1)			Yes 2 □ No	04 11 (0)					
Division	D it to	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, tarm, st	reet, factory, office	21	City or Town		or Rural Route Number,			
	To the Hospitel or Attend within 24 hours after dealt To the Funerel Director: completely filled in by the	Medical (	29a. Certifier 1万 Certifying Phy (Check only one) 1 Medical Exam	rsician: To the best of my known iner: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and place, ar pinion, death occurre	nd due to the ca	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)			
	within To th compl	Me	29b. Signature and title of certifier	0 -		29c. License	e number	2	9d. Date signed (/	Month, Day, Year)			
)			* Dall	(ix		D0041	L3 <b>3</b> 4		11/16/2	2004			
	12		30. Name and address of person who c										
			Dr. Tim Cote, MD, 31. Date filed (Month, Day, Year)			Silver Spi	ring, MD	20904					
	Sta Registi		DEC 0 2 2004	32. Registrar's Signa	1 Se	racks							
		0.04			16	-							

23, 29c, d, 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items#16a&16b perFH, C840 2/24/05 CC

Amend Items#16a&17 per fh&phy G838 12-9-04 ras

1- For Amend Item 4a&17 per fh&phy G838 12-9-04 ras
Registrar amend Item#16perfH, C841, 3/1/05 TT Certificate of Death
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Reginald A. Addison 8:45 ам /Medical 2004 4a. Facility Name (If not institution, give street and number)

Blessed

Bless House Assisted Examiner 4b. City, Town, or Location of Death 4c. County of Death ess House Assisted Living Balto Funeral 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 213-20-7333 A 1**X** M 2□F Months 78 Director 28 1926 Md Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location ?7 ie marked other than "naturei', or items 23a or 28a-f ehow treumatic event, the Medical Examinar musi be rudified al 10d. Inside City Limits Director N/A Balto 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2042 N. Bentalou Street Funeral 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 20 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2√2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: **Black** Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Fork Lift Operator 15. Decedent's Education (Specify only highest grade completed) Social Security d 2 should be filed within 7/ th and Mental Hygiene. 7 Ie marked other than "ni Elementary/Secondary (0-12) Social Security College (1-4or 5+) 8th\_grade N/AAdministration 17. Father's Name (First, Middle, Last) Augustus Addison 18. Mother's Name (First, Middle, Maiden Sumame) -Augusta Addison Griselda W. Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 le any injury or other tree once. Robert J. Addison - Brother 5363 Flight Feather Columbia. Md 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet 11-29-2004 Crownsville, Md Funeral Service Licenses 22. Name and Address of Facility March F/H 4300 Wabash Avenue Balto, Md 21215 23 . P. x 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In rediate Cause (r di ease or condition resulting in death) wediate Cause (Final Physician ung Cances /Medical Due to (or as a consequence of): Examiner hronic Obstructive pulmonary failure Sequentially list conditions, any, leading to minisorate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): VII Hospital or Attending Physiclen: The law requires that the death certificate be executed as the burial-transit Bronchitis that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death Year P.O. 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Tachycardia Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Inknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗙 No of Vital 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living Hospital: Certification: To 1 ☐ Yes 2 7 No ASSITANT 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier ٥ 29c. License number 29d. Date signed (Month, Day, Year) mD11/24/04 30115 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) 41 hiok pehal, mo 2600 Liberty HOST Are Baltymo 31. Date filed (Month, Day, Year) DEC 02 32. Resistrar's Signature State Registrar

			1 - For Stete Registrer	State of M			t of H	ealth and	Mental Hy	giene,	0.1	033
	Physic	an	1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath Day	3. Time	of Death
	/Medi		Edward	Eddie	Juder	ston	A	dair	Novemb	ser 29 2	140 has	53 AM
	Examir	ier	4a. Facility Name (If not institution, Sinai Haspi	tal of Bal	dinore	B	al	Location of De		4c. County	of Death	
	Funeral Director		5. Social Security Number 096-24-3311 Usuaf Residence of Decedent	6. Sex 7. Ag	75 Y	day) If Under Months	1 Year Days	If Under 24 H Hours M		y, Year)	9. Birthplace (State Country) VA	e or Foreign
	land ow		10a. State 10b. County		10c. City, Town	or Location					10d. Inside	City Limits
	Mary F sh	to	MD NA		Balti	more						s 2 No
	th the	Funeral Director	10e. Street and Number			10f. Zip	Code	-		10g. Citizen of W	hat Country?	
	23e	rai	4400 Ethland	Ave			21:	207		U.S.	Α.	
	er deg	nue	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Deced	ent of Hi	spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race	- American Indian, , White, etc.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 ie marked other then "neturel", or items 23e or 28e-f show enty injury or other treumatic event, it is Marical Examinator was be notified at ance.	by F	1 ☐ Never Married XXMarri 3 ☐ Widowed 4 ☐ Divorced	ed 1 X Yes 2 1 If Yes, Give Year or Dates:	No	1 🗆 Yes		Specify:		Specify:		
Maryland 21215-0036	2 hou	ted	15. Decedent	's Education	16a. D	ecedent's Usua	al Occupa	tion		16b. Kind of Bus		
2	thin 7.	pie	(Specify onfy highes, Elementary/Secondary (0-12)	t grade completed) College (1-4or 5		Give kind of woi ife. DO NOT us	rk done a se retired,	furing most of w	rorking	TOD: TAILE OF DE	anio a anio da di y	
7	filed wil Hygiene other the	Completed	12th grade	na		Manage	r			Carl's	Amoco	
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<u>a</u>	d 2 st th and 7 le n treun		19a. Informant's Name/Relationsh						Rural Route Numbe			
	1 and Health tem 27		Dorothy J. A 20a. Method of Disposition	dair-wire	20b. Place of D	JO Eth	land	d Ave,	Baltimo		21207 City or Town, State	- <del></del>
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			23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that caused	the death. Do no	enter the mode	e of dying	, such as cardi	ac or respiratory ar	rest,	Approxima	ate
	Physician		Immediate Cause (Final disease or condition	( )	no.		ρ,	1.4.			Onset and	
	/Medical		resulting in death)	Due to (or as	a consequence of)	: 0+	all	anell				
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1	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury	Due to (or as	a consequence of)	:						
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8760,	le be executed /sician and e burial-transit											
89	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical		0.								-
ROX	eath certific attending p for use as i	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	-0-				23d. Date	of delivery	
	deat ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		3 ☐ Ectopic pre 5 ☐ Other (spe				Mont		Year
J.	res that the de signed by the s be detached f	Phys	9 Unknown									
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5	sicier certii irecto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:					eath (Check only or			
Ö	y Phy ar this eral d	<b>⊢</b> ¦	27. Manner of Death	1 ☐ Inpatie	v 28b. Tim		Sc. Injury :	4 Nursing	Home 5 Reside	ence 6 Other	(Specify)	
<u> </u>	ath. r: Afte e fun	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		Year) Inju	ry M	c. Injury : Work?	es 2 🗆 No		on injury occurred	•	
UIVISION	er deg rector	ertification;	3 Suicide 6 Could no 4 Homicide determin	led 286. Place of Inju	ry - At home, farm	street, factory,	office		28f. Location (Si	treet and Number	or Rural Route Nun	n <i>ber</i> ,
5	tel or rs aft el Dii ed in	Cer		building, etc	. (Зреспу)				City or Town	n, State)		
	To the Hospitel or Attending Physicien: whin 24 hours after death at the furnition To the Funerel Director: After this certifica completely filled in by the funeral director, to	edical	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best of xeminer: On the basis of and manner state	examination and/o	eath occurred a r investigation,	t the time in my opii	, date and plac nion, death occ	e, and due to the curred at the time, d	ause(s) and mann ate and place, and	er as stated. d due to the cause(	s)
	To t To t	Σ	29b. Signature and title of certifier	40			License				Month, Day, Year)	
			Milchysk .	X4 M.D.			133	77	1	Journber	29150	PO
	1		30. Name and address of person w. Dr. MAHAJABIU	S. AU. M.D.	eath (ftem 23a) (Ty 2 \ 0	pe, Print) W. Beli	icde	ne Av	e. Baltim	ione M	. b. 2121	5-
	Star Registra	e ar	31. Date filed (Month, Day, Year)	2004 32. Registra	r's Signature	6	G. 300					

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1 - For State Registrer 38034 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 28, 2004 **Physician** Gail Lee Arlotta 3:30 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartfields at Frederick Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Days | Hours | Min. | Dec. | 29, 1943 | California 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 447-42-5554 60 Yrs. Director Usual Residence of Decedent with the Maryland 10b County 10c City Town or Location 10a State 10d, Inside City Limits in than "natural", or items 23a or 28e-f sho Maryland Frederick Frederick 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1820 Latham Drive 21701 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Budget Administrator City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Dale Lintner Helen Thomas 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is rr any Injury or other treum <u>once</u>. Mrs. Tamara E. Griffin, daughter 1704 Dear Brought Drive, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Smithsburg Crematory Nov. 29, 2004 Smithsburg, Maryland ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Reeney and Basford PA Funeral Home Dro M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician (ancer disease or condition resulting in death) -Un /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician by Physician/Medicai the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 □ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Inpatient 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by determined 4 Thomicide within 24 hours a

To the Funerel I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0041619 November 29, 2004 erner MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Lerner, M.D., 63 Thomas Johnson Drive, Frederick, MD 21702 (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 2 Registrar

Dhusia		1. Decedent's Name (First, I	Middle, Last)				2. Date of De		Year	3. Time of Death
Physic /Medi		Donald Frazie					Novemb	er 23,	2004	17:43 M
Examír	ner	4a. Facility Name (If not insti 7725 Buck H	itution, give street and number ill Road	)	4b. City, Town, or	r Location of De SVILLE	ath		unty of Death Ltimore	
Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday	If Under 1 Year	If Under 24 H			9. Birthpl	ace (State or Foreign
Director		186 34 8708	1□M 2□F 60	) Yrs.	Months Days	Hours Mi	April 3		Pittsh	ureh. PA
and		Usual Residence of Deceder  10a. State 10b. Co		10c. City, Town or L	ocation			72		Od. Inside City Limits
Marylan -f show	tor	Maryland Balt	imore	Baltimore (	auntv					1 □ Yes 2 □ No X
ith the Mi or 28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Count	
s 23a		7725 Buck Hill R			21087			USA		
Maryland 21215-0036 Id 2 should be filed within 72 hours after death with the Maryland the and Mental Pyglene. It is marked other than "natural", or Items 23a or 28a-1 show traumatic event, I's Madical Exertilist must be natified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐  3 ☐ Widowed 4 ☐ Divo	If YAs Give	?  No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ın, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		Race - America Black, White, e ecify: Whit	etc.
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121 within sne. than	Completed	Elementary/Secondary (0-		5+)	kind of work done of DO NOT use retired					
Ind 21215-0 be filed within 72 h tal Hygiene. td other than "natu	Be Co	12. Father's Name (First, Mic	ddle, Last)	Insura	nce Adjuste		lame (First, Middle		nce Indu	stry
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re, Marylan s 1 and 2 should be 1 Health and Mental item 27 is marked of other traumatic events.	or 8	19a. Informant's Name/Rela			ing Address (Street					Code)
		Eleanor K And	erson	20b. Place of Disp	Buck Hill ]	Road Kin	Sville, M	_	21087 on - City or Tov	yn State
Baltimore, bermit. Pages 1 ar Department of Hea mportant: If item: any injury or other page.		· ·	tion 3 Removal from State	cemetery, cre	matory`or other plac	´ I			9550 AO	
Baltimol permit. Pages Department of Important: If is any injury or o		21. Storature of Funeral Ser		. 2	atory Inc. I	s of Facility		Faltino	re,Mryl	ard
w sales	100	Mother	se, or complications that cause List only one cause on each	mai 1	F Lassahn Fi <del>1750 Belair</del>	ineral Ho <del>Road Kin</del>	me PA <del>osville Ma</del>	n <del>avland</del>	21087	
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uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1	a consequence or,						
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vision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificate releath. ector: Atter this certificate has been signed by the attending physy the tuneral director, page 2 should be detached for use as the	by	Part II. Other significant cor	nditions contributing to death l	but not resulting in the u	inderlying cause give	en in Part I.	23e. Did t	-		cause of death?
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Of Phys or this oral di	n: To	27. Manner of Death	28a. Date of Inju		02,0011	· Carranoning	Home 5 Residue			SCENE
siding anding ath. or: Afte	atlo	2 Accident in	vestigation	ay Year) Injury		í? ∕es 2 □No				
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To t with To t	2	29b. Signature and title once	land W			C.M.E.	1	Vovemb	er 27,	2004
		30. Name and address of pe	rson who completed cause of a	death (Item 23a) (Type, $111$	Penn Stre	et, Bal	timore, 1	Maryla	nd 2120	1
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medica	(Check only one)  29b. Signature and title Once	ortifier Arrange Completed cause of a	of examination and/or in	29c. License	number  C.M.E.	curred at the time,	date and place 29d. Date sig	ned (Mo	onth, D

			1 - For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H			ene 2004	38036
	Dhysisi		Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Medic		Charles P Becker					November	28 2004	8:00 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give st.	reet and number)		4b. City, Town, or	Location of Death		4c. County of De	
(6)			2005 Taylor Avenue			Baltimore			Baltimore	9
於	Funeral		5. Social Security Number 6. Sex	M 2 🗆 E	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )	(ear) 9. B	rthplace (State or Foreign Country)
	Director		214 12 1762 x	M 2□F 84	Yrs.			(Month, Day, ) April 28 1	1920 Ove	rleá, Maryland
	land land		10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
	Many -f sh	tor	Maryland Baltimore		Baltimore (	County				1 ☐ Yes 2 ☐ No
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	h with	ai D	2005 Taylor Avenue			21234			USA	
	deat mms 2	Funeral Director		. Was Decedent	Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	erican Indian,
9	after or Ite		1 Never Married 2 X Married	Armed Forces?  1 Yes 2 1  If Yes, Give	No	f Yes, specify Cubar		Hican, etc.)	Black, Wh	ite, etc.
003	72 hours after death with the Maryland haturel', or Items 23s or 28s-f show oldel Examination in Milled et	d by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2 ₩No	Specify:		Specify: W	rite
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12	withir ane. <b>then</b>	dm	Elementary/Secondary (0-12)	College (1-4or	D+)	DO NOT use retired)				
	filed Hygie ther int, I	ပိ	11 17. Father's Name (First, Middle, Last)	ŊΆ	Machine	e Operator	18. Mothor's Nam	e (First, Middle, Ma	Industrial	
an	d be antal ced o	$\mathbf{\omega}$	Henry Becker						uden Sumame)	
Maryland	shoul od Me mark meti	ဥ	19a. Informant's Name/Relationship (Type	Print)	19h Mailir	g Address (Street a	Teresa But		City of Town Ctate	Zin Code)
Š	ulth ar 27 Is r treu		Irma K Becker	,, ,		Caylor Avenu				Zip Code)
ē,	f Hea f Hea item othe		20a. Method of Disposition		20b. Place of Dispo	sition (Name of			c. Location - City or	Town, State
E	Page ient o nt: If ry or		1 □XBurial 2 □ Cremation 3 □ Rer  4 □ Donation 5 □ Other (Specify)	moval from State		matory or other place		Y <sub>4</sub> Ba	altimore, M	nvland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23s or 28a-f show any injury or other treumetic event, the Medical Examiner must be indiffied at sine.		21. Signature of Funeral Service Licensee	•		. Name and Address	s of Facility			
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			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused	the death. Do not enter	er the mode of dying	, such as cardiac	or respiratory arrest	i,	Approximate Interval Between
	Enysician i		Immediate Cause (Final disease or condition	<	Sudden 1	CARDIÃO	- De-			Onset and Death
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687	ficate physics the	edicai	d							
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m	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		Ectopic pregnancy Other (specify)			Month	Day Year
<u>Ф</u>	that the death	Physician/Me	9 Unknown	9□ Unknown						
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ord ord	w require been si should b							1 🗆 Yes	2 No 3 □ P	robably 4 Unknown
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_	The rate has page	Completed						autopsy performed	d? death?	completion of cause of
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
of	Physi this c	P	1 165 2410	pital: 1   Inpatie		-	4   Nursing Hor	me 5 esidenc		cify)
n C	ing After une	on	1 Sending 5 ☐ Pending	28a. Date of Injui (Month, Day		28c. Injury a Work?		28d. Zescribe how i	injury occurred	
S	Attending ir death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	On Diana of Init			es 2 □No			
Division of	F Sign	Certification:	4 Homicide determined	building, etc	rry - At home, farm, stre c. (Specify)	et, factory, office		28f. Location (Stree City or Town, S	t and Number or Ri Itate)	ural Route Number,
	spite		29a. Certifier Certifying Physic	ian: To the best of	of my knowledge, death	Occurred at the time	date and place	and due to the cours	0/0\ and manage	
	To the Hospitel within 24 hours and To the Funerel completely filled	edicai	(Check only 2 Medical Examiner one)	On the basis of and manner sta	examination and/or inv	estigation, in my opir	nion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	To the Hospitel within 24 hours a To the Funeral ( completely filled	M	29b. Signature and title of certifier			29c. License r	number	29d.	Date signed (Monta	h, Day, Year)
}			12 Jane			DY	4604		19/30/1	24
			30. Name address arson who comp	pleted cause of de	eath (Item 23a) (Type, F	rint)				- (1
	13		MICHAEL SUTER	- 95	12-HARFO	20 Rd	#4	Bronn	MORE M	D 2123x
	Stat		31. Date filed (Month, Day, Year) DEC 0 2 20		r's Signature	1	<i>A</i> .			
	Registra		V & ZU	UT PALE	1	pour	al			

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

				State of Ma	ıryıand	/ Depail	rtment of F Fificate of I	lealth and Death	Mental Hy	/giene Reg. No. 2 (	104	38037
	Physic		1. Decedent's Name (First, Middle, Le	st)	B	ook	,		2. Dete of D	eeth Dey	Year	3. Time of Deeth
	/Medi Examir		4a Fecility Name (If not institution, giv	e street end number)	1	00/		4b. City, Town, or	Locetion of Dea	th 4c. Count	of Death	130 PM
Total Control	Laurin		( a of al	rshid	How	u		Belt	more			
	Funeral		Social Security Number     6. S		(In yrs. les		If Under 1 Year Months Days	If Under 24 Hr	s. 8. Date of B		9. Birthpla	ace (State or Foreign
	Director		209 01 0622 Usuel Residence of Decedent	" 2X 94	+	Yrs.			March 7	1910		Jnion, PA
	lend #	Ì	10a. State 10b. County		10c. City, T	Town or Loca	ation				100	d. Inside City Limits
	Many	ō	Maryland Baltimore		Balt	imore (	cunty					1 ☐ Yes 2 ☐ No
	th the	Je l	10e. Street end Number	L			10f. Zip Code			10g. Citizen of	What Countr	y?
	23a c	Funeral Director	8803 Alnwick Road				21234			USA		
	tams Narm	nue	11. Marital Status	12. Wes Decedent E Armed Forces?		13. W	as Decedent of H res, specify Cuba	ispenic Origin? (: in, Mexican, Pue	Specify Yes or Norto Rican, etc.)	o- 14. Rad Bla	ce - Americar	
20	rs aft		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	0	10	☐Yes 2☐xNo	Specify:		Specif	v:	
21215-0020	within 72 hours after death with the Marylend ene. Than "natural", or frams 23e or 28e-f show he Madicel Examiner must be inciffied at	Completed by	15. Decedent's Ed	ucation	1	6a. Decede	nt's Usual Occupa	ation		16b. Kind of B	Whi usiness/Indu	
7	thin 7	pie	(Specify only highest gra	de completed) College (1-4or 5-		(Give ki life. DC	nd of work done of NOT use retired	during most of wo f)	orking			,
6.4	filed wi Hygien ther th	8	8	N/A		ousewif	e			Housekee	ping-Ow	n Home
Maryland	ild be filed lental Hygi kad other ic avant, t	Be	17. Fether's Name (First, Middle, Last)  Joseph Fletcher Me	10140					me (First, Middle		ne)	
2	should nd Men marka umatic	٩	19a. Informant's Name/Relationship	/ers		10h Mailine	Address (Christia		sellen Bri	<u> </u>		
	end 2 s ealth an n 27 is i		Donna K Lescallett	ype, rilli)			Address (Street a				. State, Zip C	ode)
ē,	of Health of Health Item 27	-	20a. Method of Disposition		20b. Place	e of Disposit	ion (Name of		Date Date	20c. Location	City or Town	n, State
Ë	it. Pages intment of I riant: If Ite njury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				tory or other place Faith Cem.		30, 2004	Baltimore	Morala	nd.
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryler Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic avant, the Maddeal Examinar must be notified at once.		21. Signature of Funeral Service Licen	S99	COLCU	22.1	Name and Addres	s of Facility		Darchible	صد لا علط او:	IKI
	88888	-1	Mostly took	o Omno	OK!		ssahn Fune 01 Belair			arl and 212	26	
	ä		23a. Part1. Enter the di ease, or comp shock, or heart failure. List only	lications the sed tone cause on each line	he death. D	Do not enter	the mode of dying	g, such as cardia	c or respiratory a	rrest,	A	pproximate nterval Between
F	Physician /Medical		Immediate Ocupe (Final	01	_	1	. /	_			Ö	Onset and Death
	Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Cardi	ac	148	rythm	<i>la</i>			01	re hour.
22		Je.		D	ue to (or es	a conseque	ince of):					
Vil	tificete be exactifed g physician end es the buriel-transit	edical Examiner	Sequentially list conditions.	b	ue to (or as	à conseque	nce of):					
90	sian e	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
68760,	physic the b	20 P	that initiated events resulting in death) Last	D.	ue to (or as	a conseque	nce of):					
X	= 5 0	400		d								
Box	deeth cert ettending d for use	by Physician/	Part II. Other significant conditions co	ntelle dine to de etc.		- !- N I						
0	t the c by the teche	ty.	$\sim$ /		not resulting	g in the unge	enying cause give	in in Par( i.		tobacco use con Yes 2□No		ne cause of deeth?
'n	es the gned be de	Š	colon (a	ncer						100 2010	O . TOBAL	ny 4 dikilowii
Records,	Ine lew requires that the deeth cer ate hes been signed by the ettendir pege 2 should be deteched for use	Completed	Hy Rutens,	ion					24a. Was	en autopsy rmed?	availa	autopsy findings able prior to
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Vital	<u>≅</u> 3. <u>₽</u>	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospitel:			Othe		ath (Check only o			
ō	a rany eral d	<b>⊢</b>  _	27. Menner of Deeth	1 ☐ Inpatient	28b	Outpatient o. Time of	28c. Injury Work	4 ⊞ Nursing H	lome 5 Resid	dence 6 Other		
0	ath. f: Afte	ate	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigetion	(Month, Dey )	rear)	Injury		? ′es 2 □ No				
DIVISION	or Attending to the function of the function o	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	At home,	farm, street	, factory, office		28f. Location (S City or Tov	Street and Numbern, Stete)	er or Rural R	oute Number,
ָ ב	urs of ur											
	to the roospizal or Abending Phy within 24 hours efter death.  To the Funeral Director: After this completely filled in by the funeral d	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Examl	sician: To the best of a ner: On the basis of ea and manner state	xamınation e	ge, death od end/or inves	curred et the time tigation, in my opi	e, date and plece inion, death occu	, and due to the rred at the time,	cause(s) and ma date and place, a	nner es state and due to the	e cause(s)
1	within To the		29b. Signature and title of certifier			, ,	29c. License	number		29d. Date signed	(Month, Day	y, Yeer)
			Offisher (m	0_127			Deas	9855		Vovemh	029	2004
_		1 3	30. Name and address of person who co	empleted cause of dea	th (Item 23a	a) (Type, Pri	nt)	1		1 1	/	
150	1-		QINGIIN GAC 31. Date filed Month, Day, Year)	mo	560	1 R	och, K	Laven	Buld	,04/+	imore	1 2/236
	Stat Registra	·	LiC 0 2	32. Registrar's	salgnature	19	pour	Es/				2004 2 2/236
				, ,								l l

			1 - For State Registrar	State of Maryland / Depa	artment of Health and Natificate of Death	Mental Hygiei Reg.	2004	38038
	Physic /Medi		1. Decedent's Name (First, Middle, Last	INIA BROOKS		2. Date of Death	Day Year	3. Time of Death
	Examii Funeral	ner	4a. Facility Name (If not institution, give LONG GREEN 5. Social Security Number 6. Se	GENESIS x 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  BALT MORE  If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.		4c. County of Dea	thplace (State or Foreign
	Director		Usual Residence of Decedent  10a. State  10b. County	M 2 10 Yrs.		3/10/192	76 500	TIT S TOCAN
	the Maryla 28e-f sho	Director	10e. Street and Number	BALTI	MORE			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show Iteal Examinat nust be notified at	Funeral Dir	4009 LANIER		10f. Zip Code  212)5  Was Decedent of Hispanic Origin? (Spriyes, specify Cuban, Mexican, Puerto	UN	Citizen of What Co	STATES
9000	nours after urel', or ite	by	1 Never Married 2 Married 3 Widowed 4 Dovorced	1  Yes 2  INo If Yes, Give 1 Year or Dates:	☐ Yes 2 ☐ No Specify:	Rican, etc.)	Black, Whi	te, etc. LACK
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumetic event, the Medical Examinat must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	le completed) (Give I	lent's Usual Occupation kind of work done during most of work DO NOT use retired)  CT PRESS	ing 16b.	Kind of Business	ANING
Maryland	2 should be file and Mental Hy is marked oth eumetic event,	To Be (	17. Father's Name (First, Middle, Last)	N	EULA	e (First, Middle, Maid	len Sumame)	
	es 1 and 2 si of Health and fitem 27 is r r other treur		19a. Informant's Name/Relationship (T)  BETTY GORDON  20a. Method of Disposition	J DAUGHTER 41009 20b. Place of Dispos	g Address (Street and Number or Run LANIER AVE. sition (Name of	BALTIME	y or Town, State, I	) 21815
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Conation 5 ☐ Other (Specify)  21. Signature of Fine fall Service Licens	ANATOM	Name and Address of Facility  Daugherty Family Funeral Ho	3/04 H	ANOVE	ER, MD
			Za. Part1. Enter the disease of compl shock, or heart failure. List only or	ications that cause. It is ath. Do not ente	2601 Mountain Road or the mode of dying, such as cardiac of	- Pasadena, MD.	21122	Approximate Interval Between
)	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	Cerziaiascolor a	discere		Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	earl failure.			Unicom
8760,	ficate be executed physician and is the burial-transit	dlcal Examin	that initiated events resulting in death) Last	Due to (or as a consequence of):	nutiz			unun
Box 68	death certificat atlending phy d for use as the	<b>a</b>	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of deli	non/
P.O. B	res that the death signed by the atte be detached for	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of death 5 □ 9 Unknown	Ectopic pregnancy Other (specify)		Month	Day Year
Records, I	The law requires that the death certif ate has been signed by the atlending page 2 should be detached for use as	by	Part II. Other significant conditions con	ntributing to death but not resulting in the und	derlying cause given in Part I.		use contribute to	the cause of death?
	nysicien: The law nis certificate has b director, page 2 st	Completed				24a. Was an autopsy performed?	death?	topsy findings available completion of cause of
<u> </u>	sicie certi irecto	o Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \) No	lospital:	26. Place of Death			
Division of Vital	ding Pl	atlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 ER/Outpatient  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	3LI DOA 4 Nursing Hon	ne 5 Residence 28d. Describe how inju		ify)
Divis	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)		28f. Location (Street a City or Town, Stat	te)	
	the Hosp nin 24 hou the Fune npletely fi	Medical	one)	ician: To the best of my knowledge, death oner: On the basis of examination and/or inversing and manner stated.	occurred at the time, date and place, a stigation, in my opinion, death occurre	nd due to the cause(sed at the time, date an	s) and manner as id place, and due	stated. to the cause(s)
	Military Villa		29b. Signature and title of certifier	MO	29c. License number	29d. Da	ate signed (Month)	, Day, Year)
	\		30. Name and address of person who con	mpleted cause of death (Item 23a) (Type, Pr	-:	ve Rist	MO:	21215
	Sta Registra	e ar	31. Date filed (Month, Day, Year) DEC 02 200		Sparks	2011		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Physician Month -rances /Medical 26 2004 5=10 PM 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore H MORR. 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Funeral Sex 1□M 2 Birthplece (State or Foreign Country) Days Hours 217-22-030 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filad within 72 hours after death with the Marylend Depertmant of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21234 Funeral Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 □ Divorced Specify: White. 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1a 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ TORC Mari 19b. Mailing Address (Street and Number or Rur Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) DALTI MORE, MD 21234 true 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Mex. Gardens 22. Name and Address of Facility

BALTI MORE, MD 21. Signature of Funeral Service License 21234. 8800HARFORD RD VAUS FUNERAL CHAPEL 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) 2 WEUKS Examiner Due to (or as a consequence of): Physician/Medical Examiner MONTHS To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 ☐ Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? 1 Tes 2 No Oronary 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: P 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Menner of Death edical Certification: 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Waturel 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 700 MIN n 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 560 XINGUN 31 Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

	•	For State Registrar		Department of Health  Certificate of Deat	and Me	•	ne 2001.	3201.0
Physician /Medica Examiner		1. Decedent's Name (First, Middle, L.  4a. Facility Name (If not institution, gi  9904 M dd 6  5. Social Security Number 6.	Kay Burto.	1, Sr. 4b. City, Town, or Location Free Class	on of Death	2. Date of Death Month NOV 2	Day Year 4, 2004  4c. County of Death  Bai / Him  9. Birth  ar) 9. County	3. Time of Death 7, 15 PM  10/e Co- place (Stete or Foreign  117)
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Evanturer rival be notified at once.	to be completed by runeral bilector	Usual Residence of Decedent  10a. State  10b. County  May Ava Balk  10e. Street and Number  19904 Married  11. Marital Status  1 Never Married 2M Married  3 Widowed 4 Divorced  15. Decedent's E  (Specify only highest gr  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Las.  19a. Informant's Name/Relationship  May Available Commatter  19a. Informant's Name/Relationship  19a. Informant's Name/Relationship	10c. City, To  Mire Co. Free  Prown Road  12. Was Decedent Ever in U.S. Armed Forces? 10 179s. Give Year or Dates:  ducation ade completed)  College (1-4or 5+)  S. Burton  Type, Print)  Wife 19  Removal from State Y	wn or Location  Letand  10f. Zip Code  Z/05 a  13. Was Decedent of Hispanic o	Origin? (Speccan, Puerto Rity:  ost of working  ther's Name  ### SSIN  ### SSIN  ### DOWN  Da  NOV  2000	(First, Middle, Maide Put Route Number, City 109. City 1	Citizen of What Cour  Control  14. Race - Americ Black, White, Specify: Loss Kind of Business/In Bin Fon  an Sumame)  Control  Co	IOd. Inside City Limits  1 Yes 21 No  Intry?  A.  San Indian, etc.  I te  dustry  Septic  (sda/e  Opde)  (MD), 2105
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit application. To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier	Due to (or as a consequence b. Due to (or as a consequence c. Due to (or as a consequence d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown ontributing to death but not resulting  Hospital: 1 Inpatient 2 Fe/O 28a. Date of Injury (Month, Day Year) 28b. 28e. Place of Injury - At home, fabuilding, etc. (Specify) ysician: To the best of my knowledginer: On the basis of examination ar and manner stated.	26. Plautpatient 3 DOA Cther: 4 North Work?  Marm, street, factory, office  29c. License number  29c. License number  29c. License number	Can C	23e. Did tobacco  1	23d. Date of delive Month  use contribute to the Contribute to the Contribute to the Contribute to c	Day Year  e cause of death?  ably 4 Unknown  by findings available npletion of cause of 2 Ho  Route Number,  ated, the cause(s)  Day, Year)

			For Stata Registrar		State of N	Marylan		artmen			nd Me		giene Rag. No.	004	38041
			Decedent's Name (Firs	t, Middle, La	st)							2. Date of Dea	ath		3. Time of Death
	Physici		Brus	رح	Buca	-ess						Month	Day	Year ઉપો	2:03PM
>	/Medic Examir		4a. Facility Name (If not in	stitution, giv	e street and numbe	r)		4b. City,	Town, or	Location of	f Death		4c. Co	unty of Death	
			NORTH ARUND		SPITAL			Gle	in E	Surn			A.	ine A	rundel
	Funeral		5. Social Security Number 220-60-9144		Sex 7.7	Age <i>(In yr</i> s 51	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Da)	, Year)	9. Birth	place (State or Foreign intry)
	Director		Usual Residence of Dece			<u> </u>	115.					JUN II	,1953	MD	
	land ow			County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Many First	to	MD AN	NE ARI	JNDEL	(	LEN BU	IRNIE							1 ☐ Yes 2 🙀 No
	th the	irec	10e. Street and Number					10f. Zip	Code				10g. Citizer	of What Cou	intry?
	23a c	Funeral Director	220 FOXTREE	DRIV	3					21061	L			USA	
	r dea	ne	11. Marital Status	37	12. Was Deceder Apped Force:	5?	S. 13.	Was Deced	lent of Hi	spanic Orig	in? (Spec	cify Yes or No- lican, etc.)	14.	Race - Ameri Black, White	
36	s afte	by Fi	1 Never Married 2		1 Yes 2 If Yes, Give Year or Dates			1 ☐ Yes 2		Specify:				noihe	
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28e-1 show dical Evantiner must be notified at	edt		ecedent's E		.1912-	16a. Dece	tent's Usua	ıl Occupa	ition			16h Kind	of Business/Ir	HITE
15	n "na	Completed	(Specify oni	y highest gr	ade completed)	- 5 - \	(Give	kind of wor DO NOT us	rk done d	urina most	of workin	9	100.11110	01 003111033711	idustry
212	d within giene. or than "	E O	12	(0-12)	College (1-4o	r 5+)	SALE	s / M	1ARKE	ETING			LO	NG FENO	CE
	2 should be filled within and Mental Hygiene. is marked other than aumatic event. It e Me	Bec	17. Father's Name (First,	Middle, Lasi	)					18. Mother	's Name	(First, Middle,	Maiden Su	mame)	
<u> a</u>	ould b	10	EDWARD J.	BURRE	SS					WANI	)A ''	UNKNOW	N "		
Maryland	2 sho and lis ms		19a. Informant's Name/R	elationship (	Type, Print)		19b. Mailir	ng Address	(Street a	nd Number	r or Rurai	Route Numbe	r, City or To	own, State, Zi	o Code)
	and lealth m 27 her tr		MRS. GLORIA		ESS / WIF			777		RIVE,		BURNI			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. Ite Medical Evantuer must be routiled at any injury or other traumatic event. Ite Medical Evantuer must be routiled at any case.		20a. Method of Dispositio 1 🔀 Burial 2 🗀 Crei	mation 3		е	lace of Dispo emetery, crer	natory or o	ther place	' I	Da			ion - City or T	
ţ	Pa men ant		'4 □Donation 5 □ 0		* *	MAR	YLAND				EC 2,			NSVILLI	
Bal	permit. Pa Depertmen Important: any injury		21. Signature of Faporal	Service 100	nsee // N	1010	101			s of Facility		GLETON			
			23 Paril Enter the disc	ase or con	nolications that caus	ed the death	Do not ent				-	., GLEI	The second secon	NIE, MI	Approximate
			23. Pm11. Enter the disc shock, or heart failu Immediate Cause (Final	re. List only	one cause on each	line.	50 1101 0111	1	o or dying	, 30011 a3 c	-	-	,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		a	cuf	<u>e</u>		CC	and	cal	inf	aut	~	one hou
	Examiner				Due to (or a	is a consequ	derice or):					q			
		je	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	is, ite	b. Due to (or a	is a consequ	uence of):								
Vil	icate be executed physician and s the burial-transit	Examiner	that initiated events	1	C										
0,	The law requires that the death certificate be exe ate has been signed by the attending physician are page 2 should be detached for use as the burial-i	Ex	resulting in death) Last		Due to (or a	s a consequ	uence of):								
8760,	ate b hysic the bi	dicai			d										
9	entific ling p	Med	IF FEMALE:		00- 15										
Box	res that the death certific igned by the attending p be detached for use as	Physician/Me	23b. Was decedent pregrin the past 12 month		23c. If yes, outcom	2 Fetal	death 3	Ectopic pro					23d	<ul> <li>Date of deliv</li> <li>Month</li> </ul>	ery Day Year
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant 9□Unknown	at time of Ge	atii 5L	Other (sp	өспу)						
P.0	that the by detail		Part II. Other significant	conditions	contributing to death	but not resu	Iting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use	contribute to t	he cause of death?
Records,	uires Isign	Completed by										194	és 2□N	lo 3 Prol	oably 4 Unknown
00	w require s been sig should b	lete										24a. Was a	ın 2	4b. Were auto	posy findings available
Re	The la	шо										autops	med?	death?	opsy findings available impletion of cause of
Vital		a	25. Was case referred to	medical						26. Place	of Death	1 ☐ Yes (Check only or	2000	1 🗆 Yes	2[[No
>	Physician: The law this certificate has b ral director, page 2 s	To B	examiner?		Hospital: 1 🗌 Inpa	tient N2	ER/Outpatien	t 3 🗆 DO	A Othe	F*		e 5 🗆 Reside		Other (Specia	(v)
J Of	ding Pth I. After th funeral		27. Manner of Death	Pending	28a. Date of In (Month, L	jury Jav Year)	28b. Time of Injury	2	8c. Injury Work			d. Describe h			,,
io	Attending in death. ector: After by the fune	atic	2 Accident	investigatio	n			М		es 2□N	lo				
Division	r Att ter de irect	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of I	njury · At ho etc. <i>(Specif</i> y	me, farm, str	eet, factory	, office		28	If. Location (S. City or Town		umber or Rura	al Route Number,
	oitai c urs af oral D	S													
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 (Check only one)	ertifying Pl ledical Exa	nysicien: To the bes miner: On the basis and manner:	of examinal	wiedge, death tion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, death	l place, ar n occurred	nd due to the c d at the time, d	ause(s) and late and pla	d manner as s ice, and due t	tated. o the cause(s)
	o the ithin 2 o the omple	Me	29b. Signature and title of	certifier				29c	. License	number		2	9d. Date si	gned (Month,	Day, Year)
	F ≥ F ŏ		)		La				0	1 PS	00	P	1	1-5	0.10
	/		30. Name and address of	person who	completed cause of	death (Item	23a) (Type,	Print)	(				,		7
_	5		and it	Ww.	M.D. 16	00 5.	Crain	House	Sui	te 10i	)	Filen	Bur	ie M	Day, Year)  U TO (
	Sta		31. Date filed (Month, Da	v, Year)	32. Regis	trar's Signa	ture		0						
	Regist	ar	UE	002	ZUU4 PA	Lapar	1	1	no.	1					

			1 - For State Registrar		Maryland / De	partment e <i>rtificate</i>				Reg. No.	2004	38042
	Physic /Medi	cal	Decedent's Name (First, Middle, CHARLES      Aa. Facility Name (If not institution,	D	arl		CAV		2. Date of D Month	Day Day	5 2004	3. Time of Death 2:09 AM
	Exami	ner	JOHNS HOPKI	ns Hosi	PITAL Age (In yrs. last birthda	BA	LTIA	ocation of Dea いのれこ If Under 24 Hrs		BA	County of Death	
	Director		236-46-1289  Usual Residence of Decedent  10a, State 10b, County	5. Sex 7.	70 Yrs.	Months		Hours Min		934 (934)	WEST	Plece (State or Foreign
	ith the Marylar or 28e-f show	Director	W BERKI	ELEY	10c. City, Town or	ARTINSBU				10- Chi-	en of What Cou	1 ☐ Yes 2 No
	ter death with items 23a or	neral Di	67 BARON DRIVE	12. Was Decede Armed Force	ent Ever in U.S. 13	2	25401	panic Origin? (	Specify Yes or Noto Rican, etc.)		USA 4. Race - Americ	
9000	within 72 hours after death with the Maryland ene. than "naturat", or items 23a or 28e-f show ha Medical Exam sections to matified at	d by Funeral	1 ☐ Never Married 2 ፟ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 Yes 2 If Yes, Give Year or Date	M No ps:	1 Yes 2	Ď No S	Specify:	to Rican, etc.)		Black, White,	etc. ITE
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla I Heath and Mental Hygiene. itiem 27 is marked other than "natural", or items 23a or 28e-1 shou tiem 27 is marked other than "natural", or items 20 to 28e-1 shou other traumatic event, the Medical Exam natural by mortified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12		(Gir	edent's Usual re kind of work DO NOT use MANAGE	k doné duri e retired)	on ing most of wo	rking		d of Business/In	
Maryland	2 should be filed withir and Mental Hygiene. Ie marked other than aumatic event, the Ma	To Be C	17. Father's Name (First, Middle, La C. CLAUDE CA	/E				LEA	me (First, Middle 1 COATES			
	is 1 and 2 sh of Health and item 27 fe m other traum		19a. Informant's Name/Relationshi  JEAN CAVE/WIFE  20a. Method of Disposition	p (Type, Print)	19b. Ma 67 20b. Place of Dis	Baron dr	R., MAF	RTINSBUR	G WV 25401		Town, State, Zip	
Baltimore,	Page nent o ent: If ury or		1 ☑ Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Special Service Li	ocity)	ite PLEASANT <sup>C</sup> GARDENS	VIEW MEN	IORY <sup>ace)</sup>	1	3/2004	MARTI	NSBURG, W	V
Ba	permit. Departn Importe any nju		23a, Part1. Enter the disease, or co	M. Br	sed the death. Do not e	32/ W. K	711/1/2 21	I., MARI.	INSBUKG MA	25402	, P.O. BO	
	Pnysician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Pue to (or	EUMONA as a consequence of:					11001,		Approximate Interval Between Onset and Death
	Examiner	lner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	ocon62/ as a consequence of):	o in	Tur	BATTO	~			WEEKS
8760, =	death certificate be executed e attending physician and of for use as the burial-transit	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a consequence of):  AMPLATE  as a consequence of):  AMPLATE  AS a consequence of):	in	E	atron Efus	i I DAV			WEBILS MONTHS
Box 687	h certificate ending phys use as the	=	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy					23	d. Date of delive	
P.O. B		Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□ Unknown	at time of death 5	□Ectopic prec □ Other (spec	city)					Day Year
	w requires that the been signed by th should be detache	by	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cau	use given ir	n Part I.		obacco uso res 2		e cause of death?
Vital Records,	The la ate has page 2	Completed									prior to con death?	sy findings available inpletion of cause of
of	Phys r this ral dii	on: To Be	25 Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1. Natural 5 Pending	Hospital: 1 N Inpa	niury 28b. Time		044	4 🗌 Nursing H	th (Check only o ome 5 Resid 28d. Describe t	dence 6	Other (Specify	
Division	or Atten frer deat Director: in by the	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of I	njury - At home, farm, s etc. (Specify)	М	1 🗌 Yes	2 🗆 No	28f. Location (S City or Tox	Street and in, State)	Number or Rural	Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the bes aminer: On the basis and manner	st of my knowledge, dea of examination and/or in stated.	th occurred at ovestigation, in	the time, o	date and place on, death occu	and due to the cred at the time,	cause(s) and p	nd manner as sta lace, and due to	ited. the cause(s)
)	To the within to the comp	Me	29b. Signature and title of certifier	ului /	40		License nu	_			signed (Month, E m3ER 2	1ay, Year) 5 ; 2004
	7		30. Name and address of person wh  AVEDIS MENES I	HAN, 600	o N. WOLF							
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	0. 1. 1						

DHMH 17 Rev 1/2001

ORIGINAL

				artment of Health and Mental Hydrificate of Death	giene 3801.
Ī	Physici /Medi		Decedent's Name (First, Middle, Last)     Thomas William Colbert	Jr. 2. Date of Deamonth December	ath Day Year 3. Time of Death
<b>)</b>	Examir		4a. Facility Name (If not institution, give street and number) 3011 Dunran Road	4b. City, Town, or Location of Death Dundalk	4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 215-22-9309  1M M 2 F  7. Age (In yrs. last birthday, 77 Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date of Birt (Month, Days Hours Min.   December	9. Birthplace (State or Foreign Country) MD.
	death with the Maryland ms 23a or 28a-f show rmst ke rivitified at	ector	MD. Baltimore Dunda	lk	10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	ath with t	Funeral Director	3011 Dunran Road	10f. Zip Code 21 222	10g. Citizen of What Country?  USA
2-003p	72 hours after de natural', or Items Yeal Eranicett.	þ	1 Never Married 2X Married 1X Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes XX No Specify:	14. Race - American Indian, Black, White, etc.  Specify: White
0-CIZI:	within ene. than "	Completed	College (1-407 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired)  Repairman	16b. Kind of Business/Industry
שנום ע	be filed ntal Hygi ed other evant, t	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	Railroad Maiden Sumame)
laryie	s 1 and 2 should be f Health and Mental itam 27 is marked o othar traumatic sv	J.		Bertha Mehoke  ng Address (Street and Number or Rural Route Number	r, City or Town, State, Zip Code)
E,	1 and Health am 27 sthar tr		20a, Method of Disposition 20b, Place of Dispo	Dunran Road, Dundalk, MD.	21222 20c. Location - City or Town, State
	permit. Pages Department of I Important: If it any injury or o		'4 □Donation 5 □Other (Specify) Oak Lawn	Cemetery December 4, 2004	Dundalk,MD.
סמ	Depa Impo any ir		There was a lower of	Onnelly Funeral Home Of D 110 Sollers Point Road, D	undalk.MD. 21222
	Physician /Medical		23a. Part1. Enter the disease or complications that caused the death Do not ent shock, or heart failure. List only one cause on each line.	or the mode of dying, such as cardiac or respiratory arms onic lung disease cancer to the lungs	est, Approximate Interval Between
/: 5	physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. and Initiate Staffic  Due to (or as a consequence of):  C. Due to (or as a consequence of):	cancer to the lungs	
	In the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  Of the Funeral Director: Agent his certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
162	w requires that been signed b should be deta	by	Part II. Other significent conditions contributing to death but not resulting in the ut		pacco use contribute to the cause of death?
200	siclan: The law re s certificate has bee lirector, page 2 sho	Completed		24a. Was an autops perform 1 🗆 Yes 2	prior to completion of cause of
	Physiclan: The this certificate his al director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (Check only one 3 DOA Other: 4 Nursing Home 5 PReside	
	tending Ph leath. tor: After th the funeral	ertification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	
	To the Hospital or Attendii within 24 hours after death.  To the Funeral Director: A completely filled in by the funeral	O	4 Homicide determined 286. Place of Injury - At home, farm, strubulding, etc. (Specify)	City or Town	•
	the Hos hin 24 h the Fun npletely	Medical	(Check only one)  2 Medicel Examiner: On the basis of examination and/or invane) and manner stated.	estigation, in my opinion, death occurred at the time, da	use(s) and manner as stated.  te and place, and due to the cause(s)
	Viit Cor	~	29b. Signature and title of certifier  Lasty Waterburg, h.D.	29c. License number 250 9559	ad. Date signed (Month, Day, Year)  Fig. 64.
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, I LARRY WATER BURY, M.D., JHBMC. 490	So 9559  Inition Eastern Que, Balt.,  Sparks	LD 21224
	Stat Registra		31. Date filed (Month, Day, Year)  DFC 0.2. 20114  32. Registrar's Signature	Souls	

State of Maryland / Department of Health and Mental Hygien 38044 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Blanche Month Louise Cottrill 2004 6:15 PM /Medical November 30, 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4827 Conowingo Road Darlington Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | October 5, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MD. **Funeral** 1 ☐ M 2 💢 F 219-01-7572 Yrs. Director Usual Residence of Decedent death with the Maryland worle 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits itam 27 is marked othar than "natural", or Iteme 23a or 28a-f ehov othar traumatic avant, the Medical Examinar must be inclifted at Director MD. 1 ☐ Yes 2X No Baltimore Dundalk 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 22 Admiral Blvd 21222 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2X No 3 Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 73 h and Mental Hygiene. 7 is marked othar than "n (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward P. Wilhelm Mora Louise Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health ant: If itam 27 i Marion Cottrill 22 Admiral Blvd, Dundalk, Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o Murial 2 ☐ Cremation 3 ☐ Removal from State December `4 Donation 5 Other (Specify) Cardens of Faith Cemetery 4,2004 Rosedale MD. 21. Signature of Fureral Service Licer Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Mus m 23a. Pany Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner erebrovasco Sequentially list conditions, Lary Leaning Cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 DEctopic pregnancy 2 Fetal death 4☐Pregnant at time of death 5 Other (specify) Day Year 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Wrombiocy topenia. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Hypeteusian 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Mer (Specify) 500 S P Aftar thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 □ Yes 2 □ No 2 Accident after death Diractor: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours aft To the Funaral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0034749 antis Danell MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthory 2112 Dundalk AVE, Dundalk, MD. 21222 Harrell 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 02 Mersine 2004 Registrar

			Eor	State of Man	/land / Dep		Health and I			e.
			1 - For State RegistrarAMFND TTFM						Reg. No. 2 0 0	4 38015
	Dharia		1. Decedent's Name (First, Middle, Las		FII (10.70_1		011	2. Date of Dea		3. Time of Death
	Physic /Medi		THELMA	t /·		Cox		Month NOV.	28 20	04 4:11 P.M
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death	1	4c. County of	
			DON DECOU			1	ALTIM	ORE		NA
	Funeral		5. Social Security Number 6. Se	9X 7. Age (li ☐ M 22XE	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day	(Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		10 113			SEPT.O	6,1914	MARYLAND
	death with the Maryland ms 23a or 28a-f show	1	10a. State 10b. County	10	c. City, Town or Lo	ocation			•	10d. Inside City Limits
	Man)	ţō	MARYLAND	) (A		Ba	LTIHOR	EAT	7/	1 ⊠Yes 2 □ No
	h the	<u>le</u>	10e. Street and Number			10f. Zip Code	LITTON		10g. Citizen of Wha	at Country?
	th wit	Funeral Directo	31 N. BENT	ALOU S	TREET		2150	3	11<	i A
	ems f	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-		American Indian,
36	or It	J.F.	1 Never Married 2 Married	1 ☐ Yes 2 ZNo If Yes, Give	- 1	1 □ Yes 2 No		o Hican, etc.)		White, etc.
5-0036	hours after tural', or Ite	d b	3  Widowed 4 □ Divorced	Year or Dates:					Specify:	SLACK
	n 72 "nat	Completed by	15. Decedent's Ed (Specify only highest grad	ucation de c <i>ompleted)</i>	16a. Deced	dent's Usual Occup	pation during most of work d)	king	16b. Kind of Busin	ess/Industry
121	withi ene. than	μË	Elementary/Secondary (0-12)	College (1-4or 5+)	N.		. 1		111111111111111111111111111111111111111	- Handing
9	filed Hygi other	Ö	17. Father's Name (First, Middle, Last)	(UNKNOWN)	1201	MESTIC	18. Mother's Nam	ne (First Middle )	UNIVERS	SITY HOSPITAL
lan	ild be lental ked cev	To Be						TIE	_	RIGGS
Maryland	2 shou and M Is mar aumat	-	19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailir	ng Address (Street	and Number or Rui		: City or Town. Sta	te. Zin Code)
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any pioury or other traumatic event, Ite Medical Examinar must be notified at once.		BERNADETTE CO.	GRAND-DAUG		21 ARC				10.21217
ore.	of He of He fiter roth		20a. Method of Disposition	2	Ob. Place of Dispo	sition (Name of		, , , , , ,	20c. Location - City	
Ĕ	Page nent ant: If		1 X Burial 2 □ Cremation 3 □ I  14 □ Donation 5 □ Other (Specify,	Removal from State	MT, ZIC	A CEMENTE	RY 12 -	24-04	LANSDOWN	E,MD,
Baltimore	permit. Page Department Important: any injury once.		21. Signature of Funeral Service Licens	00	1 , 22	Name and Addres	ss of Facility	2001115	JR. FUNE	= Pai Hame
_	8 Q E # 9		1 wether	N.Wille	ams =	约节门	H FULTO	J AVE.		· MD. 21217
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the ne cause on each line.	death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	1>	chemic	bour.			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co				,		
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/	ted 1sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):					
(	al-tra	xar	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
8760	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal		4						
.89	ifficat g phy as the	edic		J						
Вох	leath certifica attending ph I for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pr					23d. Date of	delivery
B.	deat	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at time		Ectopic pregnancy Other (specify)			Month	Day Year
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Ś	res that the de signed by the a be detached t	by	Part II. Other significant conditions co	ntributing to death but no	t resulting in the un	derlying cause give	en in Part I.			e to the cause of death?
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ec	has by	Completed						24a. Was ar		autopsy findings available to completion of cause of
Vital Records,	: The cate had	Co						perform	ned? death	res 2□ No
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:			26. Place of Death	(Check only one	9)	
ō	his I dii	٦.	1 Yes 2 No	1 ☐ Inpatient  28a. Date of Injury	2 ER/Outpatient		4 Li Nursing Ho		nce 6 Other (S	pecify)
on	Attending P death. ctor: After t y the funera	tlon	Natural 5 ☐ Pending	(Month, Day Yea	28b. Time of Injury	28c. Injury Work	rat (? Yes 2 □No	28d. Describe hor	w injury occurred	
Division	l or Attend after death Director: /	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home farm stre			28f Location (Str	oot and Number are	Rural Route Number,
á	after after Direction by	Certification;	4 Homicide determined	building, etc. (S	pecify)	ot, lactory, office	1	City or Town,	State)	nurai noute Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	alc	29a. Certifier Certifying Phys	sician: To the best of my	knowledge, death	occurred at the tim	e, date and place.	and due to the car	use(s) and manner	as stated
	ne Ho n 24 i ne Fu	edical	(Check only 2 Medical Examinations)	ner: On the basis of examination manner stated.	mination and/or inve	estigation, in my op	inion, death occurr	ed at the time, da	te and place, and o	lue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mo	onth, Dey, Year)
)	~ (		De mar	m P		D.	40854		12/1/2	004
	61		30. Name and address of person who co		(Item 23a) (Type, P	Print)	- 1			
				abes mo	ignature	St Paul	PI Ba	Himore	21202	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	K.				
	Registr	aı	DEU 0 2 2004	Janus .	C 45004					

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Maxima Ycong Chua /Medical December 2004 7:50 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Nursing Center Catonsville **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) Days 1 □ M 2 T F Months **Director** 220-86-2659 Yrs 64 Sep. 5, 1940 Philippines Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "neturel", or items 23a or 28e-f show other treumetic event. Its Medical Examinar must be notified at 10d. Inside City Limits Director MD 1 ☐ Yes 2X No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane Apt. HR639 21228 death Completed by Funeral <u>United States</u> 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry d 2 should be filed within 72 h and Mental Hygiene.
7 Is marked other then "no (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State Government <u>Accountant</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lorenzo Ycong Eusebia Tampus permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Is rr any injury or other treum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dionisio B. Chua Husband 19 Maiden Choice Ln, HR639, Catonville, 20 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 12-3-2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signatury of Funeral Service 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final abole **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death Month Year P.O. 5 Other (specify) the 9 Unknown ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, MMES 1 ☐ Yes 2 TNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 Z No 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? : After t Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funerel [ 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ione lane, Catourrelle 30, Name and address of person who completed cause of death (Item 23a) (Type, Print). U MM artell 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 0 2 2004 Registrar

			1 - For State Registrer		aryland / Depa <i>Cei</i>		of H	ealth a		ntal Hygi	-	004	3801.
	Physici /Medic		1. Decedent's Name (First, Middle, La.  Robert Charles C	urrier					N	Date of Death Month Ovember	Day 21,	Year 2004	3. Time of Death 4:15 A M
}	Examir		4a. Facility Name (If not institution, give					Location of				nty of Death	
	Funeral		Holy Cross Hospit  5. Social Security Number 6. S		e (In yrs. last birthday)	If Under 1	1 Year		4 Hrs. 8.	Date of Birth	-	gome1	TY place (State or Foreign intry)
	Director		027-28-5261	<b>X</b> M 2□F	69 Yrs.	Months	Days	Hours	Min.	(Month, Day, 1/28/19	935		sachusetts
	Maryland a-f show	tor	10a. State 10b. County  MD Montgom	ery	10c. City, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 No
	or 28s	Director	10e. Street and Number			10f. Zip (	Code			10	g. Citizen o	f What Cou	intry?
	ath w	rai	13114 Twilight C				874				J.S.A.		
396	be filed within 72 hours after death with the Maryland tal Hygiene.  dother than "natural", or itama 23a or 28a-f show event, the Modical Examinar must be mailfied at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give Year or Dates:	No	Vas Decede f Yes, speci l ☐ Yes 2		spanic Orig n, Mexican, Specify:	nn? (Specit Puerto Ric	y Yes or No- an, etc.)	BI	ace - Amer lack, White cify: Wh:	
Baltimore, Maryland 21215-0036	hin 72 hou s. na anatura Medical E	Completed	15. Decedent's Education (Specify only highest gradients)  Elementary/Secondary (0-12)	lucation	16a. Dece (Give	dent's Usual kind of work DO NOT use	l Occupa k done d e retired	ation during most	of working	1	6b. Kind of	Business/I	ndustry
21.	filed with Hygiene other the	Com	9		Auto	Parts	Dri					notive	<del>j</del>
and	ild be fill ental Hy ked oth ic even	To Be	17. Father's Name (First, Middle, Last, unk					18. Mother unk	's Name (F	First, Middle, M	aiden Suma	ame)	
ary	2 should be and Mental Is marked ( sumatic ev	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address			r or Rural F	loute Number,	City or Tow	n, State, Zi	p Code)
Z O	5 = 7 = 7		Helen L. Currier,	Daughter			100-20-2	Cour	t, Ge				nd 20874
Jore	ages 1 ar nt of Hea :: if item : or other		20a. Method of Disposition  1 Burial 2 Cremation 3		20b. Place of Dispo cemetery, cres	natory or oth	her plac				Oc. Location		
	permit. Pages. Department of H important: if ite any injury or of		' 4 ☐ Donation 5 ☐ Other (Specifical Service) Licental Service Licental S		Ft. Linco			ory   1 is of Facility		ple Tri		rood,	Maryland
Ba	Deps impo any in	1	(1) ) the	11 / L					STIII			Marv1	and 20874
	Prrysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aRespira	the death. Do not ent tory Failu a consequence of): tic Lung C	re	of dying	g, such as c	cardiac or n	espiratory arre	st,		Approximate Interval Between Onset and Death
760,	icate be executed physician and sthe burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unionlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):								Months
P.O. Box 687	The law requires that the death certificate inte has been signed by the attending physionage 2 should be detached for use as the land.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pre Other (spe						Date of deliv	rery Day Year
	quires that n signed b uld be deta	by	Part II. Other significant conditions of Urinary Tract I		ut not resulting in the u	nderlying ca	use give	en in Part I.			acco use co s 2 🌠 No		the cause of death?
Vital Records,	The law require ate has been sly page 2 should b	Completed								24a. Was an autopsy perform		b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
/ita	sician: The certificate rector, pag	Bec	25. Was case referred to medical examiner?						of Death (C	Check only one			
ŏ		. To	1 ☐ Yes 2 🔀 No 27. Manner of Death	Hospital: 1 Inpatie			-	4 🗀 1401		5 Resider			îfy)
o	Attanding r death. sctor: After by the funer	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Year) Injury	м	3c. Injury Work 1 🗆 `	k? Yes 2 □ N		3. D00011D0 1101	v injury ooo	41100	
Division	or Attar after dea Director 3 in by the	Certification:	3 Suicide 6 Could not be determined	286. Place of Inj	ury · At home, farm, str c. (Specily)	eet, factory,	office		28f	. Location (Stre City or Town,		nber or Rur	al Route Number,
	To the Hospital or Attanding Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical C			of my knowledge, deatl f examination and/or in ated.								
	To th within To th compl	Me	29b. Signature and title of certifier	a ha	Ly MI	-		number 602	2-6	29	d. Date sign	2 10	Dey, Year)
	\		30. Name and address of person who				_						1
			Kshama Garg, MD,		t Glen Roa	d, Sil	lver	Spri	ng, M	ary1and	2091	0	
	Sta Regist	ate rar	DEC 0 2 2	9.4	ure J. A	back	,						

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U J 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth Month Day USIMANO Year NORECN. Anna ember 26 2004 4a Fecility Neme (II not institution, give street end number) 4b. City, Town, or Location of De 4c. County of Death romwell ore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7 Age (In yrs. lest birthdey) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign Country) Deys 216-12-2429 Usuel Residence of Decedent 10 M 2 F Months Hours Min. Yrs 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No BALTI MOR ALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21234 USH Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dloyed Independent 17. Father's Neme (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's N. e/Relationship (Type, Print) Jonahue Dora 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Z 1 Z 34 tice of Disposition (Name of Date 20c. Location - City or Town, State Usimano-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-30-04 tarkville, MD Cemeter rword 21. Signature of Funeral Service Licensee 22. Name end Address of Facility YORKRD, TIMONIUM MD 21093 2325 REACEFUL ALTERNATIVES FUNERAGE CREMATION CTR 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Vist only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) minute Due to (or es e consequence of) Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

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funeral

or Attending Physician: The law requiras that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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Certification: To

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Funeral

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**Funeral** 

Director

28a-f show

6 Herns 23a

other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours aftar compartment of Haaith and Mantal Hygiana. Important: If them 27 is marked other than "naturel", or her pate.

death with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i.

1 Yes 2 No 3 Probably 4 Unknown

2 noras

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

25. Wes case referred to medical examiner?

1 Yes 2 No Hospitel

HIM

26. Piece of Death (Check only one) Other: 4 D Nursing Home 1 Inpatient 3□ DOA

2 No 1 Tes 1 ☐ Yes 2 ☐ No

27. Manner of Death 1 Naturel 2 Accident

3 ☐ Suicide

4 ☐ Homicide

31. Dete tiled (Month,

5 Pending investigation 6 Could not be

2000

(°0 2

28a. Dete of Injury (Month, Dey Year)

Loch

2 ER/Outpatient 28b. Time of Injury

28c. Injury et Work? 1 Yes 2 No

29c. License number

5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

29a. Certifier

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, Stete)

(Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

To the Hospital or Attending Phywithin 24 hours after death.
To the Funerel Director: After this completaly filled in by the funeral

Crack 30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print)

6

2004<sup>32. Registrer's Signeture</sup>

29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Yeer **Physician** 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2/2 F Days Hours 22-Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend nent of Heatth and Mental Hygiene. ant: If Item 27 is marked other then "natural", or Items 23e or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylent Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23e or 28e-1 show any injury or other traumatic event, Ite Madical Exertiner must be notified at 10a State 1 Yes 2 No ARKVIL 10f. Zip Code Director 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use getired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Huy MOSIZOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CAN heodore Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. onnie 71026 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 Ø Buriat 2 ☐ Cremation 20c. Location - City or Town, State Date 3 Removal from State -29-04 Timonium 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WINDRE, MD 21231 EVANS FUNERALCHAREL, 8800 HARFORD'RE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List gnly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No Live birth 3 Ectopic pregnancy been signed by the atte Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No After this certificate has 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) y LATE Hospital: Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 ZOther (Specify) 2 1 Tes 27. Manner of Death 12 Natural 2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospitel or Attending I within 24 hours after death.
To the Funerel Director: After 5 Pending investigation 1 🗌 Yes 2 No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30-Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSCEN P 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State Registrer	State of Ma	arylan		artmen rtificat				∕lental Hygid	ene N20	04	38050
Physic		Decedent's Name (First, Middle, Last)  LOUISE CAR	OLE MOR	GAN	COPE					2. Date of Death Month NOVEMBER	Day 20 2	O O A	3. Time of Death 11:50 at
/Medi Exami		4a. Facility Name (If not institution, give st			0011	4b. City,	Town, or	Location of	of Death	MOVINGE CONTRACTOR	4c. County		11:30 a
	2	Washington Adventis	t Hospit	al		Tak	oma	Park			Montg		7
Funeral Director		5. Social Security Number 6. Sex 579-58-1025 Usual Residence of Decedent	7. Ag	9 (In yrs. 1	last birthday) Yrs.	If Under Months	1 Year Days	if Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, ) June 19,	1945	9. Birthp Coun <b>Hav</b>	lace (State or Foreig try) Vaii
Deficient of the proof of the control of the control of the many of the control o	To Be Completed by Funeral Director	10a. State 10b. County  Maryland Prince G  10e. Street and Number  9202 Autoville Driv  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educa (Specify only highest grade)  Elementary/Secondary (0-12)	e  2. Was Decedent Armed Forces? 1	Co Ever in U.	16a. Deced (Give life. Prog	Park  10f. Zip 20  Was Deced f Yes, spec 1  Yes 2  dent's Usua kind of wor DO NOT us ram A	ent of Hi ify Cuba EXNo I Occupa k done of e retired,	Specify:  Ition uring mosi stant 18. Mothe	of work	ecify Yes or No-Rican, etc.)	14. Race Blace Specify b. Kind of Burden Communication Surmanners	White  winess/Industry  white  winess/Industry  whent	
and 2 auth a salth a n 27 is		Richard Cope / sp	ouse			Autov				College Pa			
Dallinote, Demil. Pages 1 a Department of Hea mportent: If item iny injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ( <b>X</b> Cremation 3 ☐ Rei	noval from State	20b. PI	lace of Dispo	sition (Nam	e of her place	9)	410		c. Location -		
thent of l		* 4 ☐ Donation 5 ☐ Other (Specify)		Wes	st Arui	ndel (	Crem	. 1	2/1/	2004	Odento	n, Ma	ryland
Departing any ir		21. Signature of Funeral Service Licensee		40077						iome, P.A. Laurel,		and	20707
/Medical Examiner buysician /Medical Examiner the prival-transit	ai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	Consequ	ionico Offi:	feil		na fu	un	a cak			
death certifi e attending I od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal	death 3	Ectopic pre					23d. Date Mon	of deliver	<b>y</b> Day Year
9 5 9	þ	Part II. Other significant conditions coptr	buting to death bu	t not resu	iting id the un	derlying ca	use give	n in Part I.					cause of death?
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or Attending Phy after death. Director: After this in by the funeral d		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	. :	28b. Time of Injury		c. injury Work		2	28d. Describe how i			
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At hor (Specify)	me, farm, stre	et, factory,	office		2	28f. Location (Stree City or Town, S	t and Numbe tate)	r or Rural	Route Number,
ne Hospi ne Funer letely fill	edical	29a. Certifier (Check only one) 12 Certifying Physic 2 Medical Examiner	ian: To the best of : On the basis of and manner stat	axamınatı	vledge, death on and/or inv	occurred a estigation, i	t the time n my opi	, date and nion, death	place, a	and due to the cause ad at the time, date	e(s) and man and place, ar	ner as sta nd due to t	ted. he cause(s)
To the To the To the Comp	Me	29b. Signature and title of certifier				29c.	License	number	,	29d.	Date signed	(Month, D	ay, Year)
							5	61	47	7	// /	/2 ×	1116
974		30. Name and add ss of person who	pleted cause of de	ath (Item :			, ,	<b>A</b>			1	5	101
∬ Sta Registr		NASKEEN Z 31. Date filed (Month, Day, Year) DEC 0 2 2002	32. Apoistra	's Signatu	ure	ARRO	//	AVE.	- 7	AKOMA	PARK	, Ma	1 20912

				State of Maryland / Department State of Maryland / Department Certification	nt of Health and N te of Death		ne No.2004	38051
_		Physici		1. Decedent's Name (First, Middle, Last)  John Daniel Chetelat, Sr.		2. Date of Death Month NOUCE	Day 29 Year 2004	3. Time of Death
		/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City	, Town, or Location of Death		4c. County of Death	
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months	er 1 Year   If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthpla Country 1920 Mary 1	
		٠, ١		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		Suite 20;		d. Inside City Limits
		deeth with the Maryland me 23a or 28a-f show const be notified at	tor	Maryland Baltimore Catonsville				1 ☐ Yes 2 No
		or 288	Director	7	ip Code		Citizen of What Countr	y?
		eeth w	Funerai		228		SA 14. Race - American	n Indian
	36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mantal Hygiene importents if item 27 ie marked other than "natural", or iteme 23a or 28a-f show amy injury or other treumatic event. It may light a factorinal be notified any once.	y Fun	Armed Forces? If Yes, spe  1 □ Never Married 2 □ Married If Yes ⊆ □ No  If Yes Give WWIT 1 □ Yes	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 X No Specify:	Rican, etc.)	Black, White, et	c.
	Maryland 21215-0036	2 hours	ted by	15. Decedent's Education 16a. Decedent's Usu	ual Occupation	166	p. Kind of Business/Indu	
	121	within 7 ane. Ihan "r	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	ork done during most of work use retired) ndustrial Ope		odomol Com	
	d 2	il Hygie other	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		rnment
	ylar	ould be Menta	70 E	John H. Chetelat	Mary Mur			
	Mar	and 2 shallth and 27 ie m			ss (Street and Number or Rur ding Place: Ba		VLCCVIS SURVINO	code)
	ore,	of Head of Head if Item		20a. Method of Disposition 20b. Place of Disposition (Na	ame of		. Location - City or Tow	n, State
	altimore,	iit. Pag artment ortent: injury c		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Gother (Specify) entomb  Crest Lawn Men  21. Signature of Funeral Service Licensee.			erriottsvil	
	Ba	Dermi Depar impor any ir		Hote S. Call Ster	and Address of Facility Ling Ashton Se Edmondson Aver	chwab Fune nue; Cator	eral Home, asville, MD	Inc. 21228
_		40-305-		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.			li C	Approximate nterval Between Onset and Death
		Pnysician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):	ord-ovascu	nlor di	scosc u	Lour
e/-	1	Examiner	-	Sequentially list conditions,  b. Due to jor as a consequence of				
76		outed Id ansit	Examiner	Sequentially list conditions, and the last cause. Enter Underlying Cause (Disease or injury that initiated events				
S	8760,	cate be executed physician and the burial-transit		resulting in death) Last  Due to (or as a consequence of):				
رسا	9	certificate iding phys	Medi	IF FEMALE:				
4	О. Вох	death	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic p 4 Pregnant at time of death 5 Other (s			23d. Date of delivery Month D	ay Year
5	rds, P	ires sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did tobacc	co use contribute to the	
2	Record	law as b 2 sl	Completed	hypertension		24a. Was an autopsy performed 1 Yes 2	prior to comp	y findings available bletion of cause of
0	Vital	Physician: this certificinal director,	Be	25 Was case referred to medical examiner?  Hospital:	Othon	h (Check only one)	-	
3	JC	ding Phys	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of	4 Transing No	ome 5 Residence 28d. Describe how in	6 □Other (Specify)	
5	Division	el or Attending F s after death. il Director: After id in by the funer.	icatio	2 Accident investigation 3 Suicide 6 Could not be	1 ☐ Yes 2 ☐ No	29f Location (Street	t and Number or Dural C	Zouta Alumbar
2	DIV	s after all Direct of in by	Certification;	4 Homicide  28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ry, office	City or Town, St	t and Number or Rural F tate)	noute reuniber,
0		To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred and manner stated.	d at the time, date and place, n, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as state and place, and due to th	ed. ne cause(s)
		To t To t COM	×		9c. License number		Date signed (Month, Da	
		1241		80. Name and address of person who completed cause of death (Item 23a) (Type, Print)	, 00 - 0 (		sucmber	
		0		31. Date filed (Month, Day, Year) 32. Registrar's Signature	-s Health	care K	Saltino	576
		Sta Registr			ak			

			1 - For State of Maryland / Del	partment of Hea ertificate of Dea			ene g. N2 0 0 4	38052
Ī	Physici	an	Decedent's Name (First, Middle, Last)     RUBYNETTE V. COOPER			2. Date of Death Month NOVEMBER	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 1802 POPLAR AVE.	4b. City, Town, or Loca ANNAPOL	cation of Death	NOVEMBER	4c. County of Death	
	Funeral Director		5. Social Security Number  6. Sex 1		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, 16-2-193	Year) Co	nplece (State or Foreign untry) (LAND
	Maryland -1 show	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or           MD •         ANNE ARUNDEL         ANNAPO					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28a	Funeral Director	10e. Street and Number	10f. Zip Code		109	g. Citizen of What Co	untry?
	ns 23s	erai	1802 POPLAR AVE           11. Marital Status         12. Was Decedent Ever in U.S.         13. Was Decedent Ever in U.S.	21401 3. Was Decedent of Hispan	nic Origin? (Spe	cify Yes or No-	USA 14. Race - Amer	ncan Indian,
2	72 hours after death with the Marylan "natural", or liems 23a or 28a-1 show idical Examiner must be notified at	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes, Give Year or Dates:	If Yes, specify Cuban, Mo	lexican, Puerto F pecify:	Rican, etc.)	Specify: BLA	
200		Completed	(Specify only highest grade completed) (Gillege (1-4or 5+)	cedent's Usual Occupation ve kind of work done during b. DO NOT use retired)	n ng most of workir	ng 16	6b. Kind of Business/I	,
מומ ל	B d ala	To Be Co	-122-  17. Father's Name (First, Middle, Last) HARRY WALKER		Mother's Name VIOLA P.	(First, Middle, Ma	FOOD SERV	ICE
la l	s 1 and 2 should f Health and Men itam 27 is marke other traumatic	-		illing Address (Street and N				
ב ט	Health tam 27 other tr		20a Method of Disposition 20b. Place of Dis	2 POPLAR AVE	-		RYLAND 214 0c. Location - City or 1	
	Pages ment of I ant: If its ury or o		1 13 Burial 2 Cremation 3 Hemoval from State  14 Donation 5 Other (Specify) HILLCRES	rematory or other place)  CEMETERY	12-4-		NNAPOLIS,	
Dail	permit. Pages 1 and 2 Department of Health a Important: If itam 27 le sny injury or other trat			22. Name and Address of 821 WEST ST.				
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not estable, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	inter the mode of dying, su	ich as cardiac oi	r respiratory arres	t.	Approximate Interval Between Onset and Deathy
,000	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):					
.O. DOA .O.	the death certific the attending p ched for use as i	Physician/Me		B Ectopic pregnancy 5 Other (specify)			23d. Date of deliv Month	very Day Year
, ,	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in	Part I.	23e. Did toba	cco use contribute to	the cause of death? bably 4 Unknown
2011	rsician: The law re s certificate has bee lirector, page 2 sho	Completed	HyperTension			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
A II C	ician: certifica rector,	Be	25. Was case referred to medical examiner?	Other		(Check only one)		
5	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	tion: To	1   Yes 2   No	of 28c. Injury at	2	ne 5 Aesidend 8d. Describe how	ce 6 Other (Speci injury occurred	fy)
	al or Atten s after deal id Director: id in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	2	8f. Location (Stree City or Town,	et and Number or Rur State)	al Route Number,
	ne Hospita n 24 hours ne Funera pletely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal of the best of my	ath occurred at the time, da investigation, in my opinior	ate and place, a n, death occurre	nd due to the caus d at the time, date	se(s) and manner as s a and place, and due t	stated. to the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifier    Signature and title of certifier   M.D.	29c. License num	765	29d	Date signed (Month,	Day, Year)
	N		30. Name and address of person who completed cause of death (Item 23a) (Type	H	Ann	muli	W>1 2-1	401
	State 31. Date filed (Month, 19), Year)  Registrar  A State 31. Date filed (Month, 19), Year)  State 31. Date filed (Month, 19), Year)  A Sports  A Sports							

N	00	•	For Unpend Item 23ac27 per me 6838 in Registrar	artment of Health and M rtificate of Death	lental Hygi	ene g. No 2 0 0 4	38053
	Physicia /Medica	_	John H. Dugger		2. Date of Death Month Novembe:	1	3. Time of Death 2308 P M
	Examine		aa. Facility Name (If not institution, give street and number) Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
16%	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F  7. Age (In yrs. last birthday)  6. Sex 1 F  7. Age 1 F  6. Sex 1 F  6. Sex 1 F  6. Sex 1 F  6. Sex 1 F  6.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthp Cour -42 VIV	lace (State or Foreign try)''
0	Maryland	tor	10a. State 10b. County 10c. City, Town or Lo	ocation MORC		1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28i	al Director	100. Street and Number 1526 N. Patterson PK	101. Zip Code 21213	10	og. Citizen of What Cour	ntry?
980	ours after death with the Marylar ral; or items 23a or 28a-f show Examinar must be molified at	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Bl	
Maryland 21215-0036	within 72 ho ene. then "natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki OO NOT use retired) CRE house YMA	ng	6b. Kind of Business/Ind CLover L	
yland		To Be (	Robert 1. Dugger	18. Mother's Name	M, 5	Stith	
	1 and 2 s Health ar em 27 ls ther trau		MARQUERITE DUQGER 1520 20a. Method of Disposition 20b. Place of Disposition	ng Address (Street and Number or Rura  By Ratteles ov  Institute (Name of matory or other place)	PK A	City or Town, State, Zip  VC, Boldo  Oc. Location - City or To	. Md.
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 □ Burial 2 □ Cremation 3 □ Hemoval from State  1 □ Donation 5 □ Other (Specify)  MIT 2	on Cemeters 12/	4 pos Han Ch	Baltimon padury, Brasel P. C	e Md.
	Pnysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Atherosclerotic Cause (Final disease or condition	er the mode of dying, such as cardiac o	r respiratory arre		Approximate Interval Between Onset and Death
8760,		dical Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				
9	ath certifi	hysician/Medi		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
rds, P.	quires that the de	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		acco use contribute to th	
Reco	sician: The law require certificate has been shirector, page 2 should to	Completed		<del></del>	24a. Was an autopsy perform	24b. Were autoprior to condeath?	osy findings available appletion of cause of
Division of Vital Records, P.O. Box	Phy this	To Be	25. Was case referred to medical examiner?  ↑★ Yes 2 No  1 Inpatient 2 Inpati	The second secon		ice 6 □Other (Specify	)
Divisi	al or Attandi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
		Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deatt 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cau and at the time, dat	use(s) and manner as state and place, and due to	ated. the cause(s)
	K mi	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		d. Date signed (Month, L ovember 25,	
_	(a, ba		104	<sub>Print)</sub> <b>Penn Street, Balti</b>	more, Ma	aryland 2120	)1
	Stat Registra		31. Date filed (Month, Day, Year) DEC 0 2 2004  32. Registrar's Signature	Sparks			

State of Maryland / Department of Health and Mental Hygiene 38054 For Stata Registra Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 10:00 Am. M Nov 24, 2004 Milton Dorsey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Harbor Side Health Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☑ M 2 ☐ F Director Yrs. Sep 8, 1930 217-26-9200 74 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes Ž ☐ No Completed by Funeral Director Randallstown **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4820 Valey Forge Road 21133 fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. √Yes 2 No fYes, Give rear or Dates: 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1951 1 ☐ Yes 2 ☑ No Specify: Black 3 ☐ Widowed 4 ☑ Divorced "neturel". 1954 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) B & A Rail Road **Bus Driver** 12 treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Pris marked of Pages 1 and 2 should be Milton Gross Emma Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Importent; If item 27 4820 Valey Forge Road Randallstown, Maryland 21133 Delores Burgess or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury 12/08/04 Owings Mills , Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any ir Estep Brothers Funeral Home P.A 1300 Eutaw Place Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physician and Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Ao
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 2 No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 200 No certificate 1 ☐ Yes within 24 hours after death.

To the Funerel Director: After this certifies completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide o the Hospital within 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and who completed cause of death (Item 23a) (Type, Print) 60 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 0 2 2004 Registrar

			1 - For Stete Registrar	State of Maryland / I	Department of Health and I Certificate of Death		(1111la	38055
	Dhunini		Decedent's Name (First, Middle, L.)	ast)	- Commodity of Dodain	Reg. 2. Date of Death Month	140.	3. Time of Death
	Physicia /Medic	al	George Hard intitution of	F. Deshona	4b. City, Town, or Location of Death		Day 301, 2 Vear	
	Examin	er	4a. Facility Name (If not in stitution, g	n Medical Cente			4c. County of Deat	timore
İ	Funeral		.000	Sex 7. Age (In yrs. last bit	irthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birtl	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	/ / / / / / / / / / / / / / / / / / / /		11-30-0	5 181	msylvania
	show	ក	10a. State 10b. County	10c. City, Tow	wn or Location			10d. Inside City Limits 1 ☐ Yes 2 No
	r 28a-f	irect	10e. Street and Number	010	10f. Zip Code	10g.	Citizen of What Co	*
	ath witi	ralD	4207 Morris	sville. No.	21161		USA	
_	fter de	Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Amued Forces? 1 ☑ Yes 2 ☐ No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
2	ural', o	by	3 Widowed 4 □ Divorced	l(Yes, Give Year or Dates:	1 ☐ Yes 210.No Specify:		Specify: (U	hite
5	n "nati	Completed	15. Decedent's (Specify only highest of		a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	rking 16b	. Kind of Business/l	Industry
7 7	ed with ygiene ver tha t, the	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	perating Cigines	1 1		NON#37
2	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. Ind Mental Hygiene. Inakted other than "natural" or itams 23a or 28a-f show unatic event, it a Modical Examinational be notified a	To Be	17. Father's Name (First, Middle, La.	Do Shore 5	18. Mother's Nar	ne (First, Middle, Maid	den Sumame)	·
	2 shoul and Me Is mark	ř	19a. Informant's Name/Relationship	(Type, Print) 191	b. Mailing Address (Street and Number or Ru	iral Route Number, Cil	0	Tip Code)
ນ໌ ນົ	1 and 2 Health am 27 I		20a, Method of Disposition	-loyd-SON /	Of Hilltop twe.	Date 20c	MD 2/ Location - City or	DOWN State
2	Pages nent of h int: If Ite		1 Burial 2 Cremation 3	Removal from State cemete	ery, crematory or other place	2-4-04 B	e (Air n	10wh, state
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, in a Madical Examination ust be notified at once.		21. Signature of Funeral Service Lic	1100111	22. Name and Address of Facility	AUTIMOR	- 1	21234
			23a. Part1. Enter the disease, or co	implications that caused the death. Do	o not enter the mode of dying, such as cardiac	or respiratory arrest,	Horr feurd	Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition			YNDROME		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence CHRONIC OBS	on: Tructive fulmonaf	Y DISEAS	E	YEARS
	· =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	of):			
	xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence	of):			
00/00	ficate be executed physician and is the burial-transit	edical E	(	d				
Š Č	centifica ding ph se as th		IF FEMALE:	23c. If yes, outcome of pregnancy			22d Date of deli	
DOX.	The law requires that the death certifate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of deli	Day Year
	hat the ed by th detach		9 Unknown	s contributing to death but not resulting	in the underlying cause given in Part I	23e. Did tobaco	o use contribute to	the cause of death?
coras,	quires t in signe uld be	ed by	-	F RIGHT LUNG	and and any ing sause given in that it	2/		obably 4 □Unknown
2	law relas bee	Completed				24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
חומוו	Physician: The lavithis certificate has al director, page 2					performed 1 ☐ Yes 2 🔀	? death? No 1 ☐ Yes	2 No
<b>=</b>	ysicla iis certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2♥ No	Hospital: 1 Inpatient 2 ER/O		ith <i>(Check only one)</i> ome 5□ Residence	6 ☐Other (Spec	ify)
5	ing Ph		27. Manner of Death 1 Natural 5 ☐ Pending	(Month, Day Year)	Time of 28c. Injury at Work?	28d. Describe how in		· · · · · · · · · · · · · · · · · · ·
VISION	Attand r death actor: by the f	Certification;	2 Accident investigat 3 Suicide 6 Could not determine	be 28e. Place of Injury - At home, fa	M 1 ☐ Yes 2 ☐ No farm, street, factory, office	28f. Location (Street	and Number or Ru	ral Route Number,
5	ttal or urs afte ral Dir		4 Homicide	building, etc. (Specify)		City or Town, St	ate)	
	To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier  (Check only one)  Certifying I  2 Medical Ex	Physician: To the best of my knowledg eminer: On the basis of examination ar and manner stated.	ge, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier	Colon M.D.	29c. License number		Date signed (Month	
	./X1		, , ,	o completed cause of death (Item 23a)	D 17695	NEC	rinee s	20,2004
	151		ABDALLAH J. H	HELOU, M.D., 76		WSON, MA	RYLAND :	21204
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Signature	& Sparks			

State of Maryland / Department of Health and Mental Hygiene? [] [] [] 38056 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4:00 PM 27 2004 William Nov. Dorse /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TSON 6. Sex NIE BUR COUNTY DOT ANE EN If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (Stete on Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 10 M 20 F 215-07-7562 LAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SON -ANE 1060 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Baltimore, Maryland 21215-0036 Specify. δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) URNER ERATOR HEMICAL 3RD GRADE permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Itam 27 is marked other any injury or other trauments. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be TURNER GEORGE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) N BURNIE MD 21068 20c. Location - City + Town, State LANE GLEN WIFE 007 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State HALLS CHURCH CEME. GLEN BURNIE 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4 one Funeral dr. PDCe 13A140 MO21217 2140 Fulton rehics 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Calon Concer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate full linder, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medicai as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Year ō Month Dav 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? res 2 No has page 2 certificate 1 ☐ Yes Physician: completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Certification: To Be Other: Hospital: 1 ☐ Yes 2 ☐ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) After Injury or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat e Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the I 29d. Date signed (Month, Pay Year) 29c. License numbe 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 2016 CM Burnie 7575 Ritchie Anil HOPE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death November 27 **Physician** 30 A.M **Edwards** Richard 2114 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Huspital Burnie 4nne Arundel Arundel Birthplace (State or Foreign Country)
 Maryland If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Aug 27, 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) Months Hours 1 ★ M 2 🗆 F Yrs. Director 216-14-3043 83 Usual Residence of Decedent 10a. Slate 10b. County 10c. City. Town or Location 10d. Inside City Limits or than "natural, or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Glen Burnie Directo Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? U.S.A. 21061 102 N. Crain Highway by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 □ No If Yes, Give 1 Never Married 2 Married 1945 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: **Black** 3 Widowed 4 Divorced Year or Dates: 1946 Completed 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) K & K Trucking Co Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 12 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Gertrude Hall James Edwards 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 N. Crain Highway Glen Burnie, Maryland 21061 Sarah Edwards Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/03/04 Pasadena, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Mt Zion Church Cem 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Estep Brothers Funeral Home P.A 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner IASETES Sequentially list conditions if any, leading to introdicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medical the IF FEMALE: esn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has birector, page 2 s 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 1 Tes 2 ER/Outpatient 3 DOA Division of 28b. Time of Injury 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred Certification: After the Hospital or Attending Natural
2 Accident death. 1 Yes 2 No investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier ny dress of person who completed cause of death (Item 23a) (Type, Print) drive 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma	ıryland		artment of rtificate o				iene g. No.2	004	38058		
			1. Decedent's Name (First, Middle,	Last)						2. Date of Deat Month	h Day	Year	3. Time of Death		
	Physicia /Medic		MARGARET M. I	FILBERT			,		N	OVEMBER		2004	10:20 A.M		
	Examin		4a. Fecility Name (If not institution,				4b. City, Town	, or Location	of Death			unty of Death			
			GOOD SAMARITAN I		//= /-		BALTI If Under 1 Year	MORE C		0. Date of Righ	N,		(0) 10 5		
	Funeral Director		5. Social Security Number 216-24-4504	- C	14 14	as <i>t birthday)</i> Yrs.	Months Day		Min.	(Month, Day,	Date of Birth (Month, Day, Year)  8/2/1930  9. Birthplace (State or Fo Country)  MARYLAND				
			Usual Residence of Decedent							3/2/193	0	MARY	LAND		
	yland		10a. State 10b. County		10c. City	, Town or Lo	ocation					1	0d. Inside City Limits		
	r 28a-f show	ctor	MD BALT	IMORE	PA	RKVILL	Æ						1 ☐ Yes 2 🙀 No		
	ith th	Director	10e. Street and Number				10f. Zip Code	9		10	0g. Citizen	of What Coul	ntry?		
	ath with		1801 FORREST RO				212				US				
	er de Items	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		5. 13.	Was Decedent of If Yes, specify Co	if Hispanic Or uban, Mexica	rigin? (Spec in, Puerto F	cify Yes or No- Rican, etc.)		Race - Americ Black, White,			
36	i', or	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	10		1□Yes 2XIN	lo Specify	:		Sp	өсіfу: WHI	TE		
215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-1 show Jical Examiner must be notified at	ted	15. Decedent's	s Education	1	16a. Dece	dent's Usual Occ	cupation			16b. Kind	of Business/In			
215	.⊆ ⊇	pie	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  12TH GRADE  16b. Kind of Business/Indu (Give kind of work done during most of working life. DO NOT use retired)  MEDICAL SECRETARY  MEDICAL OFF												
21	in the state of th	Con	12TH GRADE			MED	ICAL SE					CAL OF	FICE		
nd	d d o	Be	17. Father's Name (First, Middle, L.					18. Moth	ier's Name	(First, Middle, A	Maiden Su	mame)			
<u>yla</u>		은	AUGUST HERZ		CGLONE										
Maryland	12 should h and Mer 7 la marke traumatic		19a. Informant's Name/Relationshi				ng Address (Stre			Route Number, BALTIMO					
-	1 and Healt em 2 ther	THE PROPERTY OF SON STATE DOOD TOOK DANG DA													
Baltimore	0 = 50		1 ABurial 2 Cremation		ce	metery, crei	matory`or other p MEM。PA		11/30	/2004					
뜵	permit. Par Departmen Important: any injury		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Sen/ice L		Pioru		2. Name and Add						OME, P.A.		
Ba	permit. P Departmo Importar any injur		Hoall	N. Hard			521 LOC		1110		SON,		286		
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused	the death		-						Approximate Interval Between		
	Priysician		Immediate Cause (Final	anily one cause offeach in									Onset and Death		
	/Medical		disease or condition resulting in death)	aDue to (or as		ience of):	10011	27776	- //	VIIICI	7000		14 mar 163		
	Examiner		O montality liet and divine	ATHERO	SOLE	ROTIC	1 yocan Conor	VARY	VASO	CULAR	Dise	MSE	UNUNOWN		
	D #	ner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as		ience oi):	,								
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Biper			9								
760,	be executed sician and burial-transit		resulting in death) East	D to (or as	a consequ	ience ot):									
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X 6	death certificat attending phy d for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnar	псу					23d	. Date of delive	any		
Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnal Other (specify)				200	Month	Day Year		
P.O.	at the de by the a tached	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown						_					
s, P	The law requires that the ate has been signed by the bage 2 should be detache	by Pł	Part II. Other significant condition	•		ılting in the u	nderlying cause	given in Part	I.	23e. Did tob	acco use	contribute to the	ne cause of death?		
rds	quire en sig uld bi	pa pa	jtz,	partension	7					1 □ Ye	s 2 🗆 N	lo 3 🗆 Prob	ably 4 Munknown		
Record	aw requ s been 2 shouk	piet								24a. Was ar		4b. Were auto	psy findings available mpletion of cause of		
Ä	The law cate has page 2	Completed								perform		death?	2□ No		
Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?							(Check only one	9)				
of V	dis d	오	1 ☐ Yes 2 No		100	_	nt 300A	Other: 4 N		ne 5 🗆 Reside			y)		
ם		27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?													
Division	ten leat lor: the	Certification:	2 Accident investigation inves	ot be	At he			☐ Yes 2 ☐		9f Location (St	root and M	umbar ar Dun	I Route Number,		
Σ	after death after death Director: ,	rtif	4 Homicide determin	28e. Place of Inju- building, etc	. (Specify	me, tarm, st	reet, factory, offic	28	2	City or Town	, State)	umber or Hura	i noute Number,		
	pital ours sours a eral filled		29a. Certifier 12 Certifying	Physician: To the best of	of my know	wledge deat	h occurred at the	time date a	nd place, a	nd due to the ca	use(s) and	d manner as s	tated		
	24 hc 24 hc 8 Fun etely	Medical	(Check only 2 ☐ Medical E	xaminer: On the basis of and manner sta	examinati	ion and/or in	vestigation, in m	y opinion, de	ath occurre	d at the time, da	ite and pla	ice, and due to	the cause(s)		
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier				29c. Lice	ense number		29	d. Date si	gned (Month,	Dey, Year)		
	- > - 0			Ozan			-	4048	50	1	10van	4600	29, 2004		
	10		30. Name and address of person w	who completed cause of d	eath (Item	23a) (Type,	Print) 7	602	136	dair	RM				
	V		FERNANDO	> FERRE	mo	7		1341	12, H	4D 2	123,	6			
	Sta	ite	30. Name and address of person w  TERMANDO  31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure	L s	r							
	Regist	ar	FEF (	1 6 LUU4 🕨 🗡	Maria		D Se	rocks	/						

State of Maryland / Department of Health and Mental Hygiene 004 38059 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year FISCHER **Physician** RICHARD :00 AM LUTHER 27 2004 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOS PITAL **Examiner** MD BALTIMORE JAMARITAN G00D Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F 1917 222 07 1723 87 January 21 Rhode Island Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a State than "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Baltimore Baltimore County Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 4001 Walnut Avenue Pages 1 and 2 should be filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. XYes 2 □ No 1 Never Married 2 Married If Yes, Give Year or Dates: WW II Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than GE Fischer Printing Accountant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I John G.E. Fischer Christina M. Schnell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 | Mary M Fischer 4001 Walnut Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of
Importent: If it
eny injury or o 1 □XBurial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cem. December 1 2004 Baltimore Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility lassahn Funeral Home Inc 13SCW 7401 Belair Road Baltimore, Maryland 21236 ter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ROSTATE METASTATIC CANCER Sequentially list conditions, Qualto for as a nonsequence off Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last nding physician and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ funeral director, page 2 should be FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown ATRIAL Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2/2 No 1 Tyes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours a 24 hours Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Makonnen, 10058009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE. ZELALEM MAKONNEN 5601 LOCM RAVEN BLVD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 110 0 2 2004 Registrar

Hospital or Attending Physicien: 24 hours a

Medical within 2 To the State

29a. Certifier

29b. Signature, and title of certifier

30. Name and address of person

Registrar DHMH 17 Rev 1/2001 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

November 27, 2004

				partment of Health and Mental H	211117 38081				
	Physici	an	1. Decedent's Name (First, Middle, Last)  OWEN  FRINK	2. Date of D	Day Year				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death					
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months   Davs   Hours   Min.  , #(Month, L	Sirth 9. Birthplace (State or Foreign Country)				
	Director		Usual Residence of Decedent	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1, 154				
	Marylan I-f show	tor	mb 10b. County 10c. City, Town or L Baltimo		10d. Inside City Limits 1 ☑ Yes 2 ☐ No				
	with the a or 28s	Director	100. Street and Number 1602 Bentalou St.	101. Zip Code 2 1 2 1 6	10g. Citizen of What Country?				
	tems 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	0.011				
3036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show the Modical Examinat must be notified at	b	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: Black				
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan in of Health and Mental Hygiene.  In of Health and Mental Hygiene.  In file m 27 is marked other than "naturel, or flems 23a or 28a-f show or other traumatic event, the Macical Examinal must be notified at	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry				
	ould be filed withi Mental Hygiene. Brked other than atic event, III w	Be Con	9th 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	le, Maiden Sumame)				
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	ToB	Lester Frink  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	Susie Frink ling Address (Street and Number or Rural Route Num	than City or Town State 7in Code				
	1 and 2 s Health an Gem 27 Is i		Linda FRINK - daughter 1602	2 Bentalou St. Balt	more, mo 21216				
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 eny injury or other tr. <u>once.</u>		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)	ematory or other place)	Baltimore, MD				
Balti	permit. Pag Department Importent: I eny injury o			22. Name and Address of Facility	21233				
			23a. Part1 Enter the diseate, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		arrest,  Approximate Interval Between Onset and Death				
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a	ntes Aurol	Onosi and Doam				
	Examiner	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	the					
V·T	and I-transit	Examiner	if any, leading to immediate  Substituting the substitution of the	ol Tusukurus					
8760	icate be executed physician and s the burial-transit	dicai E	d.						
ox e	eath certific attending p	a)	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of delivery				
.O. B	that the dealed by the att	Physician/M		Other (specify)	Month Day Year				
I Records, P.O. Box 68760,	uires that n signed t	d by P	Part II. Other significant conditions contributing to death but not resulting in the		tobacco use contribute to the cause of death?  Yes 2 □ No 3 □ Probably 4 □ Unknown				
lecol	e law requir has been si le 2 should l	Completed by	1 dy per 1. podomia	24a. Wa aut	24b. Were autopsy findings available prior to completion of cause of death?				
Vital F	sicien: The law certificate has E irector, page 2 s	Be Cor	25. Was case referred to medical examiner?	1 ☐ Yes  26. Place of Death (Check only	2 No 1 Yes 2 No				
of V	Physicien: er this certifica eral director, I	2	1 ☐ Yes 2 ☐ MoSpital: 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d. Describe	sidence 6 Other (Specify)				
Division of	utending death. ctor: Afte y the fun	Certification:	1 Accident 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, s	Work?  1 Yes 2 No  treat factors office.	(Street and Number or Rural Route Number,				
Div	ital or A		4 Homicide Setermined building, etc. (Specify)	City or To	own, State)				
	To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, dea  2 Medical Examiner: On the basis of examination and/or is and manner stated.	th occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time	e cause(s) and manner as stated.  a, date and place, and due to the cause(s)				
	To t To t	Σ	29b. Signature and title of certifier	29c. License number  Daa4a	29d. Date signed (Month, Day, Year)  1 → -1 -0   1				
	И		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	10101				
	Sta		31. Date filed (Month, Day, Year)  DEC 0 2 2004  32 Registrar's Signature	12 21201					
	Regist	rai	DEC ON LOUGH JOSEPH JOS						

Registrar

				State of M			artment of h				ene _	<i>(</i> ) <i>(</i>	4
			For State Registrar			Ce	rtificate of	Death		Reg	No. U	UL	38063
	Physici		1. Decedent's Name (First, Middle, Peter	Gueno						Date of Death Month	Day 4	Year 2004	3. Time of Death,
	/Medic Examin		4a. Facility Name (If not institution,	4b. City, Town, o	or Location o		0.0	4c. County					
			Howard Covi	nty Gene	eral		Colu	mbi	a		Ho	war	-d
	Funeral			. Sex 7. Ag	e (in yrs. last		If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birth (Month, Day, Y			ace (State or Foreign
	Director		523-16-8828 Usual Residence of Decedent	74	81	Yrs.			De	cember 22,	1922	C	olorado
	land ow		10a. State 10b. County		10c. City, T	own or Lo	ocation					10	d. Inside City Limits
	s 1 and 2 should be filad within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or itams 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notified at	ector	Maryland It and Number	loward		<u> </u>	El	ty	100	1 Tes 2			
	th with 23a or	Funeral Director	5500 Montgomery Ro	,			Tot. Zip Code	210	43	109	U.S.A.		
	r dea	ner	11. Marital Status	12. Was Decedent Amped Forces?	Ever in U.S.	13.	Was Decedent of I If Yes, specify Cub	Hispanic Original	gin? (Specif 1, Puerto Ric	y Yes or No- an, etc.)		e - America ck, White, e	
	ours afte	b	1 Never Married 2 Married 3 Widowed 4 Divorced	1 NYes 2 1 If Yes, Give Year or Dates:	<sup>No</sup> 1942 1940	2	1□Yes 20 No	Specify:			Specify	y: V	Vhite
ל ל	72 ho natur	Completed	15. Decedent's (Specify only highest	Education grade completed)	1	6a. Dece	dent's Usual Occup	Usual Occupation 16b. King work done during most of working					* .
7	Aithin ne. han "	du	Elementary/Secondary (0-12)	College (1-4or		life.	DO NOT use retire	id)				Government	
1	ilad v Hygie ther t		17. Father's Name (First, Middle, La	5+			reuei	al Emplo	•	First, Middle, Ma	iden Suman	201	
ylali	2 should be filad within and Mental Hygiene. is markad other than aumatic event, the Ma	To Be		/ W. Gueno	10.0				, 3 mamo (r		nie Baco		
2	2 sh and is m		19a. Informant's Name/Relationship	(Type, Print)			ng Address (Street				-		Code)
ב ט	1 and Health Sm 27 Sher tr		Mr. Harry Gueno	Son			5500 Montgolosition (Name of	mery Ka	Date		c. Location -		un State
5	parmit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		1 Burial 2 Cremation 3	Removal from State	ceme	etery, cre	matory or other pla	· I	44/20	/2004			Maryland
	it. Partmer		* 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Li				remation Sel		IU.	72004	Оук	COVIIIC, I	viai yiai ia
a	parmit. Depart Import any inj		Mountalko	MANIA	LUIDISE	0	Slack	Funeral	Home, F	P.A	and a supply	04049	
74	6 2 - 0		23a. Part1. Inter the disa. In or or shock, or heart fail tra. List or	omplications that cau ex	d the death. I	Do not en	3871 ( ter the mode of dyi	Old Colu ng, such as	cardiac or re	ce Ellicott C aspiratory arrest	ity. ND.		Approximate
	Dhysisian		Immediate Cause (Final	nly one cause on each li									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Due to (or as	a consequen	ce of):	ten I	TIEU	111011	1/-1			
	Examiner		O	b	Adr	Van	ced 1	Den	rent	19.			
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequen	ice of):							
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							1,41			
ç,	oe axa cian a	E	1000tilling in abality 2000	Due to (or as	a consequen	ice or):							
0	physic the t	dlcal		d									
ر د	To the Hospital or Attending Physician: The law requires that the death certificate be axacuted within 24 hours after death.  Within 24 hours after death.  To tha Funeral Diractor: After this certificate has baan signad by the attending physician and completely filled in by the funeral director, page 2 should be detachad for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	,					23d. Dat	te of deliver	v
ב	death a atter	clar	in the past 12 months?	1□Live birth 4□Pregnant a	□Ectopic pregnanc □ Other (specify) _	у			Mo		Day Year		
į	t the c by the achae	hys	9 Unknown	9□ Unknown									
r r	s tha	by P	Part II. Other significant condition	s contributing to death b	out not resultir	ng in the u	ınderlying cause gr	ven in Part I.		23e. Did tobac	cco use cont	ribute to the	cause of death?
Š	w require baan sig should b									1 🗌 Yes	2 🗆 No	3 Proba	ibly 4 Unknown
נ נ		Completed								24a. Was an autopsy	24b. \	Were autop	sy findings available
	The ate h page	Con								performe	92   0	death?	<b>№</b> No
2	sician: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?						of Death (C	Check only one)			
5	hysi this c	2	1 Yes 2 No	Hospital: 1 Inpatio			IL 3 DOA			5 Residence			
5	ling F After funer	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	lb. Time o	Wo	ryat rk? ]Yes 2 □ 1		I. Describe how	injury occurr	red	
2	death.	icat	2 Accident investiga 3 Suicide 6 Could no	t be and Black of Ini	iury - At home	a farm st	reet, factory, office	163 2		Location (Stree	at and Numb	er or Rural	Route Number
2	l or A after Dira	Certification:	4 Homicide determin	building, el	tc. (Specify)	, , , , , , , , ,	root, radiory, office			City or Town, S	State)	0. 0. 170.07	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To tha Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying	Physician: To the best	of my knowle	dge, deat	h occurred at the ti	me, date an	d place, and	due to the caus	se(s) and ma	inner as sta	ited.
	ne Ho 7 24 h na Fu sletel)	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Date of Dat									the cause(s)	
	To the To the Comp	Σ	29b. Signature and title of certifier				29c. Licens	se number	_	29d	. Date signer	d (Month, D	Pay, Year)
	4		25	ew			1)3	064	(	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ovem	nz/2	4 2004
	10		30. Name and address of person w		death (Item 23	Ba) (Type,	Print)	a , N/-	-60	med 1	Solhin	Inm L	Veriland Dina
			Ramesh Sab	132. Registr	rar's Signatur	159	ac 150	CIIVE	EKK	erry 1	rey 1 111	W/C /	or your year
	Sta Regist		31. Date filed (Month, Day, Year) DEC 0 2 2004	32. Registr	0	1	parker						
*	3	. 4			-	- 1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Eleanore Μ. Horn 8-2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OSE DALE 1QUARE 11 more Tranklin Birthplace (State or Foreign Country)
 PA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 TXF 196-14-1998 80 Director Aug 21,1924 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d, Inside City Limits MD 1 ☐ Yes 2X No Baltimore Director Wilson Point the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1212 Third Road 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐XNo Specify ò 3 ₩ Widowed 4 Divorced White Year or Dates naturef Completed marked other then "natu metic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail 1 and 2 should be filed withi Health and Mental Hygiene. SAles 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alvin Laudermilch Susan Ramsey ၉ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: if item 27 is eny injury or other treu 404 Amy Drive Abingdon MD David Horn /son 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HollyHillCemetery 12/1/04 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Homeof Essex 21. Signature of Funeral Service License 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cere disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) the 9 Unknown Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? Division of Vital Records, 5 2 No 3 Probably 4 Unknown 1 Tyes Completed

has le 2 certific Be 2 this Certification: Director: /

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 TYes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 2□No 112 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Man r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 🗆 No

29d. Date signed (Month, Day, Year)

within 24 hours To the Funerel

or Attending Physicien:

Hospital

the

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

30. Name and address of person

no completed cause of death (Item 23a) (Type, Print)

Frankl

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0000

Himore, MD.

			For State Registrar	State of Ma		partment of F ertificate of			giene 004	38065		
	Physicia	an	Decedent's Name (First, Middle,)	Carl D.	. Holst	on		2. Date of Dea		3. Time of Death 5:05amm		
	/Medic Examin		4a. Facility Name (If not institution, g		ar.	4b. City, Town, o	r Location of Death	1	4c. County of Death Baltimor			
	Funeral		5. Social Security Number 6		(In yrs. last birthda			8. Date of Birth				
L	Director		212-34-0562  Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location		Abili		ry Land Od. Inside City Limits		
	Maryla a-1 sho	ctor	MD Balti	more		Rosedale				1 □ Yes 2 ➡No		
	with the	Director	10e. Street and Number 1312 Spring	Ave.		10f. Zip Code 21237			10g. Citizen of What Cour	itry?		
036	be filed within 72 hours after death with the Maryland tall Hyglene. did other than "naturel", or Items 23a or 28a-f show event, the Medical Exchrimental to indifficular	by Funeral	11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specif White			
ດ່າ	vithin 72 ne. han "na	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th	Education grade completed) College (1-4or 5	+) (G.	cedent's Usual Occup ive kind of work done a. DO NOT use retired rker	ation during most of wor d)	king	16b. Kind of Business/Ind State Saw	•		
<u>_</u>	should be filed vold Mental Hygie marked other tematic event, III	To Be C	17. Father's Name (First, Middle, La Percy N. Hol			ne (First, Middle, Crusse	o, Maiden Sumame)					
	d 2 sh th and th sn traum traum		19a. Informant's Name/Relationship Raymond Holst					or Rural Route Number, City or Town, State, Zip Code)  Road Baltimore MD				
m	permit. Pages 1 and 2 Department of Health Important: if item 27 i any injury or other tra once.		20a. Method of Disposition  1 □ Burial 2 Tremation 3  4 □ Donation 5 □ Other (Spe	☐Removal from State	20b. Place of Dis	sposition (Name of rematory or other place wCremato) 22. Name and Addre	ry 11/	Date 30/04	20c. Location - City or To Baltimore	wn, State		
Balt	permit. Depart import any inj		21. Signature of Funeral Service Li		FuneralHo							
	Pnysician /Medical		23a. Part 1. Enter the disease, or conshock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	Disecse	Approximate Interval Between Onset and Death							
	Examiner	Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a consequence of).								
8760,	icate be executed physicien and s the burial-transit	dical Exar	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):							
Division of Vital Records, P.O. Box 6	The law requires that the death certific tte has been signed by the attending f age 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	,		23d. Date of delive Month	ory Day Year		
ds, P	luires that n signed b ıld be dete	by	Part II. Other significant condition	s contributing to death bu	-	e underlying cause giv	en in Part I.		bacco use contribute to the	4		
al Recoi	: The law requir cate has been si , page 2 should	Completed	(	) "				24a. Was a autop perfor	sy prior to cor med? death?	psy findings available inpletion of cause of		
f Vita	Phyaician: Th this certificate al director, paç	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	nt 2 ☐ ER/Outpa	tient 3 DOA Oth	or:	ath <i>(Check only or</i> Iome 5 🗆 Resid	ne) ence 6 □Other ( <i>Specif</i> )	1)		
sion o	ding After funer	Certification:	27. Manner of Death  1	t he	Year) Injur	y Wor M 1	y at k? Yes 2 ∐No		ow injury occurred	I Davida Niverbar		
Ω	ital or Al		4 Homicide determin	building, etc	(Specify)	street, factory, office		City or Tow				
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical E:	Physicien: To the best of ceminer: On the basis of and manner sta	examination and/o	r investigation, in my o	pinion, death occu	rred at the time, o	cause(s) and manner as sidate and place, and due to	the cause(s)		
)	To T To 1	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Month,			
	b		30. Name and address of person w		eath (Item 23a) (Type (- 1 c G	De, Print)	River	neck	nd Bal.	1221 himaso		
	Sta Registi		31. Date filed (Month, Day Year)	2 2004 P	s Signature	B Apri	uls		777			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Gloria 2004 4:35 PM Desponher /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimore Johns Hoplans Baymon Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year)
July 29,1930 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Hours 74 233-48-8592 Director WV. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumetic event, the Medical Exact if are invalided at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No by Funeral Director Baltimore Dundalk Md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21222 8113 Longpoint Road **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clara Flosie Buchanon Wade Hampton Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8113 Longpoint Road, Dundalk, Md. 21222 Edgar Hamilton Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition December 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Holly Hill Memorial 4 Donation 5 Other (Specify) 3, 2004 Middle River, MD 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point ROad, Dundalk, MD. 21222 23a. Part1. Enter the disease or complications that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final **Physician** 1 hour Mynotia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** withdrawal of mechanical ventilation 1 hour Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner MYTONIZ brain : njur The law requires that the death certificate be exec as the burial Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 N Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Tobacco 450 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funerel Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 1, 2004 Temiel Hora and RE4-000 Medical Housestell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paniel Wang 4940 Eugtern Avenue, Bultmore, My 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 2 2004 Registrar

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			For Stete Registrar	State of	Marylan	-	artment rtificate				•	giene Reg. No.	nnl.	380	68
	Physici	an	1. Decedent's Name (First, Middle	, Last)						2	. Date of De Month		Year	3. Time of	Death
	/Medic		Margaret Lo			one					ovembe			2:52	РМ
1	Examin	er	4a. Facility Name (If not institution,	•	iber)				Location of	of Death			County of Death	mao la	
			7105 Redmiles R 5. Social Security Number		7. Age (In yrs.	last hirthday)	If Under	urel r 1 Year   If Under 24 Hrs.   8			. Date of Bir		ince Geo		r Foreign
	Funeral Director		551-12-9204	1 □ M 2/F	83	Yrs.		Days	Hours						r ur <del>u</del> igii
			Usual Residence of Decedent				L			11_		-	111010		
Z	a how	<u>.</u>	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						1	0d. Inside Cit	-
Ž	- 88 - 41	octo		George's	Lauı	cel								1 🗆 Yes	
with 1	a or 2	吉	10e. Street and Number	Dord			10f. Zip	2070	17			10g. Citi	zen of What Cour USA	itry?	
4	18 23	era	7105 Redmiles	12 Was Docor	dent Ever in U	S. 13	Was Decede			gin? (Specif	fv Yes or No	)	14. Race - Americ	an Indian	
5-0036	l tan	Funeral Director	1 Never Married 2 Marrie	Armed For	ces? XXNo						fy Yes or No can, etc.)	i	Black, White,	etc.	
036		by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Da	tes:		1 □ Yes 🕽	ON KD	Specify:				Specify: Whit	e	
5-0	natu	etec	15. Decedent' (Specify only highes	s Education t grade completed)		16a. Dece	dent's Usual kind of worl DO NOT use	l Occupa k done di	tion uring mos	t of working		16b. Kir	nd of Business/Inc	dustry	
21215-0036	should be filed within ? and Mental Hygiene. Is markad othar than ". sumatic event, Ire Med	Completed by	Elementary/Secondary (0-12)	College (1-	4or 5+)		<i>bo not us</i> keeper					IIS	Governme	nt	
	Hygie thar t		12th 17. Father's Name (First, Middle, L	ast)		18. Mother's Name (First, Middle, Maiden Su									
Maryland	kad o	Tr. Father's Name (First, Middle, Last)  Edward H. Hoevel  Clara							ra Ma	ry Hen	nmett				
ary	and M s mar	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru								er or Rural F	Route Numb	er, City or	Town, State, Zip	Code)	
2 3	alth and 27 I		Sharon Lee U'Re	n/Daughte	r	7105	Redmi	lles	Road	l, Lau	rel, N		20707		
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	XXRemoval from S	- 1	lace of Dispo semetery, crei	nsition (Nam matory or ot	e of her place	9)	Dat	8	20c. Lo	cation - City or To	wn, State	
ti m	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or othar traumatic event, Ite Medical Examinational be notified at Ance.		`4 ☐ Donation 5 ☐ Other (Sp	ecity)		versid				.2/6/2			rside, (		
Baltimore,	Depar Impor any in		21. Signature of Funeral Service L	2 / 10	0.0160								eral Hom D 20707	ne, P.A	<i>4</i> •
			23 Part 1. Enter the disease, or	- reference									20707	Approximate	
			shock, or heart failure. List of Immediate Cause (Final	only one cause on ea	ich line.						00p//2(0.) u		1	Interval Betw Onset and D	veen
	hysician /Medical		disease or condition resulting in death)	a	lzheime or as a conseq		Isease	≥, E1	ia st	.age			-		
E	xaminer														
1	-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. Due to (d	or as a conseq	uence of):									
V 1	and trans	Examiner	that initiated events resulting in death) Last	C											
8760,	sician and burial-transit			Due to (c	or as a conseq	uerice oi):									
687	physi s the b	glc		d											
Box (	attending ph	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy										3d. Date of delive	ery	
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P.O	ned by the a	hys	9 🗆 Unknown	9□ Unkno	wn										
S, T	igned be det	by	Part II. Other significant conditio	ns contributing to de	ath but not res	ulting in the u	nderlying ca	iuse give	n in Part I.		_	_	se contribute to th		
ord	been si	ted								- 1	10,	Yes 2X		abiy 4 □U	nknown
Records,	Cause Enter Underlying									24a. Was autor	psy	24b. Were autor	psy findings a npletion of ca	vailable use of	
											1 ☐ Yes	rmed? 2∑XNo	death? 1 ☐ Yes	2 <b>X</b> ] No	
of Vital	is certific director,	Be	25. Was case referred to medical examiner?	Hospital:		58/0		. Othe		and the same of th	Check only o				
O	ar this sral di	): To	1 ☐ Yes XXNo  27. Manner of Death	28a. Date o	patient 2 🗆 f Injury	28b. Time o		Bc. Injury Work			d. Describe I		Other (Specify	')	
Vision	ath. r: After e funer	ation	XXNatural 5 Pending 2 Accident investig	1	n, Day Year)	Injury	М		? ′es 2 🔲 l	No					
Division	after death.  Diractor: A	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	nod 286. Place	of Injury - At he g, etc. (Specif	ome, farm, str	eet, factory,	office		281	f. Location (S City or Tox		Number or Rura	l Route Numb	oer,
	rs after al Dirac	Cert													
To the Hoenite	within 24 hours after death.  To tha Euneral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one)	Physicien: To the Exeminer: On the ba	sis of examina	wledge, deat tion and/or in	h occurred a vestigation,	at the time in my op	e, date an inion, dea	d place, and th occurred	d due to the at the time,	cause(s) date and	and manner as st place, and due to	ated. the cause(s)	
4	vithin o tha	Med	29b. Signature and title of pertifier	2.10 1141111			29c.	License	number			29d. Date	signed (Month, i	Day, Year)	
	->=0		► UTI					0548	53			Nove	ember 29	2004	
			30. Name and address of person y	no completed cause	of death (Iten	n 23a) (Type,	Print)								
	10		Danny Lee		herry		Laurel	L, M	D	20707					
:	Sta		31. Date filed (Month, Day, Year)		gistrar's Signa	lture	Soon	1.1							
	Registr	ar .	DEC 0 2 20	DA Sel	wa	10	apour	3/							

		1 - For State Registrar	State of Maryland	/ Depa		Health a	- 4	lygien Reg. N	_		380	
Physic /Medi Examii	cal	1. Pecedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give s Anne Arundel Medic	rreet and number) cal Center		4b. City, Town,	or Location of		Month Day Nov. 25, 4c. Cou			3. Time o 0220 undel	of Death M
Funeral Director		5. Social Security Number 6. Sex 219-54-4243	7. Age (In yrs. la M 2 7 92	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of (Month, Jun.	Birth Day, Yea 8, 1	912	9. Birthpi Coun	lace (State try) MI	
6 Maryland la-f ehow	ctor	10a. State 10b. County  MD Anne Art		Town or Lo		erna P	ark			10	0d. Inside C	City Limits s 2√ No
with th	i Director	10e. Street and Number  5 Whittier Court			10f. Zip Code	1146		10g. C	. Citizen of What Country?  USA			
DESILITIOTE, INIGITYIGITION ZINIONO  Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event; Ite Medical Exemplear must be notified at ange.	ed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Educ	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of if Yes, specify Cult 1 Yes 2 Note No.	Specify:	in? (Specify Yes or Puerto Rican, etc.)		14. Race Black Specify: Kind of Bus	, White, 6 Wh	ite	
rithin 72 ne. nen 'ne e Medic	Completed by	(Specify only highest grade	Completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retin	o during most ed)	of working	100.			iusti y	
Balfilmore, Maryland ZIZI3-UU30 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mantal Hygiene. Important: If item 27 is marked othar than "natural", or any njury or othar traumetic event, the Medical Exercitions.	To Be Cor	17. Father's Name (First, Middle, Last) William R. Offu	2 tt		Homema	18. Mother	's Name (First, Midd		HOME den Sumame)			
VICITY 12 shou 12 shou h and M 7 is mar		19a. Informant's Name/Relationship (Typ. William Offutt John					ror Rural Route Nur le, Oakla		tate, <i>Zip</i>	Code)		
MOFE, I Pages 1 and nent of Healt int: If itam 2: Iry or other 1		20a. Method of Disposition  1 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)	20b. Pla	ice of Dispo	esition (Name of matory or other platery)	300)	Date Nov. 27,	20c.	20c. Location - City or Town, State  Baltimore, MD			
DEILLII permit. P Departme Importan any injury		21. Signature of Finne Al Service Licensed  23a. Part1. Enter the disease, or complication shock, or heart failure. List only on					2004 s, P.A. Se					Home
that the death certificate be executed that the death certificate be executed by the attending physician and detached for use as the burial-transit	icai Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Seven and the second seco	Due to (or a a conseque	ence of):	1	e J M	ONL'S	y arrest,			Applosina Interval Be Onset and	te tween Death
the death certificant the attending phoched for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)						23d. Date Mont			Year
quires that t n signed by uld be detai		Part II. Other significant conditions con	tributing to death but not resul	ting in the u	nderlying cause g	iven in Part I.			use contrib		e cause of a	
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VICE sician: certific irector.	o Be (	25. Was case referred to medical examiner?	ospital: 1 ☐Inpatient 2 ☐ E	P/Outgation	3 7 704 0		of Death <i>(Check onli</i> sing Home 5 Re		6 0015	(0		
Jing Jing After fune	-	27. Manne eath 1 atural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Inju	ary at ork?	28d. Describ				)	
Ital or Attancins after death ral Diractor:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)					Town, Sta	te)			nber,
To the Hospital or within 24 hours after To the Funaral Director completely filled in	edicai	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	riedge, death on and/or in	n occurred at the t vestigation, in my	ime, date and opinion, death	I place, and due to the control occurred at the time	ne cause( e, date a	s) and mani nd place, an	ner as sta id due to	ated. the cause(s	s)
To the within 2 To the complete	Me	29b. Signature and title of certifler			29c. Licen	se number	-1	29d. D	ate signed.	Month, E	Day, Year)	
AS		30. Name and address of person who con		23a) (Туре, с <i>Юс</i> и	7.3	DU-1	MD:	$\frac{1}{2}i^{2}$	102	0-1		
St Regist	ate	31. Date filed (Month, Day, Year)	32. Segistrar's Signatu		as the	in ap	1010					-

Johnnie Jones Amend Item 8 per SH C845 07/19/05dhb Amend Item 8 per SH C845 07/19/05dhb Amend Item 1&Unpend Item 23a,27,28a-f. per me C838,12-28-04 tas Centricate of Death 04 - 07552MAN 2004 3. Time of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth Johnnie Jones Month **Physician** Na THanie November 23, 2004 1857 P /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Prince Georges Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/24/1952 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 M 2 □ F Yrs 578-76-1790 Monroe, N.C. Director Usuel Residence of Decedent the Merylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Washington 1 ☐ Yes 2 No D.C Director or 28a-f #3 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code be filed within 72 hours efter death with 3532 Minnesotta avenue SE. Lited States Herns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? unk
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 ☐ Never Married 2 Merried Baltimore, Maryland 21215-0020 ò Black 1 ☐ Yes 2 No Specify Specify: ģ 3 Widowed 4 Divorced "natural" Completed 16e. Decedent's Usual Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) el Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Kesidentia 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) permit. Peges 1 and 2 should be filt Depertment of Health and Mentel Hy Important: if Item 27 is marked oth any injury or other traumatic even ance. Be Nathaniel Johnnie JONES ESSIE Kobinsor 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SE. #3 inda M. Wilson-Jones/wife 3532 Minn. Gre. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Kive rdale ( 12/2/04 Kiverdale, MD remotor 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility B.K. HENRY F. H.C. 21. Signature of Funeral Service Licensee NE Wash M01178 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Praysician /Medical Immediate Ceuse (Final disease or condition resulting in death) a Narcotic (Morphine) Intoxication Examiner Due to (or es e consequence of) Medical Certification: To Be Completed by Physician/Medical Examine or Attending Physician: The law requires that the deeth certificete be exacuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, physician Due to (or as a consequence of) 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TIZN'SE BLIND 1 Xyes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XXYes 2 □ No this 28b. Time of Fourity: 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred unk 5 Pending investigation 1 Naturel 6:00 P M 1 ☐ Yes 2 📆 No 11-23-04 2 ☐ Accident 6X Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3532 Minnesota S.E. Washington, D.C. 20019 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

filled in by the funerel efter death. 24 hours Hospital сопретель

Found: Residence 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature end title of certifier

15

29d. Date signed (Month, Day, Yeer) 29c. License number

O.C.M.E.

November 24, 2004

eted cause of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Registrar

31. Dete filed (Month, Day, Year) DEC 0 2 2004

32. Registrar's Signature

To the I

		1	For State Regist Name (First Middle I	State of M	aryland / Depa	artment of He <i>pificate of D</i>	alth and Men <i>eath</i>	tal Hygien	001	38071					
	Physicia		1. Decedent s Mario (First, Wilder, E	1		-	2. [	Date of Death Month D	ay Yeer	3. Time of Death					
	/Medic	al	Linus		ism	4b. City, Town, or L		Month When	21, 2007	7:16AM					
	Examin	er	4a. Fecility Name (If not institution, gi	n Secours Hos		45. City, Town, or Li	Baltimore		N/A	4					
	Funeral Director				ge (In yrs. last birthday) 81 Yrs.		If Under 24 Hrs. 8. [ Hours Min. (	Date of Birth Month, Day, Yea Jul 14, 192	9. Birtho Cour 23 N	place (State or Foreign htry) laryland					
	and ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation			1	0d. Inside City Limits					
	a-f sh	ctor	Maryland 1	\/A		Balti	more			1 Yes 2 No					
	with the	Dire	10e. Street and Number 237 N. Gilmor Street			10f. Zip Code	21223	10g. C	Citizen of What Cour U.S.A	•					
36	72 hours after death with the Maryland natural', or Items 23s or 28s-f show dical Exertimer stast be notified at	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces: 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	<sup>No</sup> 1943		panic Origin? (Specify Mexican, Puerto Rica Specify:	Yes or No- n, etc.)	14. Race - Americ Black, White, Specify: E						
21215-0036	72 hour "natural dical Ex	eted t	15. Decedent's I	Education	1946 16a. Dece	dent's Usual Occupati kind of work done du DO NOT use retired)	on ring most of working	16b.	Kind of Business/In	dustry					
2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Exercitrations to necitive an once.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) II/e.	Lab			Bethleher	n Steel					
pue		Be	17. Father's Name (First, Middle, Las	Johnson		1	8. Mother's Name (Fin		faiden Sumame) Johnson						
Maryland	should nd Mer marke	၉	19a. Informant's Name/Relationship		d Number or Rural Ro			Code)							
», <b>™</b>	and 2 eelth a m 27 ls		Anna Brandford		eet Baltimore, I	-		Chata							
Baltimore,	Pages 1 ament of He lent: If itam		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec	eify)	CROWSVIII Garrison Fo	matery of other place)	comptery 12/	03/04	Location - City or To	Maryland					
Balt	Dependit Dependit Import eny in 20008.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Estep Brothers Funeral Home P.A.  1300 Eutaw Place Baltimore, MD 21217  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate												
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death liseases or condition  See S S S S S S S S S S S S S S S S S											
		iner	Sequentially list conditions, if any, leading to immediate cause. Extern 139 ying Cause (Disease or injury	b Due to (or as	a consequence of):										
60,	ficate be executed physicien and is the burial-transit	edical Examiner	that initiated events resulting in death) Last												
68760,				d				1							
P.O. Box	requires that the death certific een signed by the attending f hould be detached for use as	Physician/M	IFFEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						23d. Date of delivery Month Day Ye						
	ires that signed b		Part II. Other significant conditions		but not resulting in the $a$	inderlying cause given	in Part I.		o use contribute to t 2 X No 3 ☐ Prot	ne cause of death?					
Division of Vital Records,	e law has b	Completed by	Lorge Sucr	ul decub		24a. Was an autopsy performed?	prior to co death?	psy findings available mpletion of cause of							
ita	ysiclan: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death (Ch								
of \	₩ 5	۲.	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Minpat		The second second	4   Nursing Home	5 Residence		y)					
ion	ling After	atlon	1 Natural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, Date)	ay Year) Injury	Work?	es 2 No	DOGGING HOW III	jary obsumou						
Divis	or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	a 1 286. Place of In	ijury - At home, farm, st tc. (Specify)	reet, factory, office		Location (Street and City or Town, Sta	and Number or Rura ite)	al Route Number,					
_	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edical Co			t of my knowledge, deat of examination and/or in tated.										
	To the within 2 To the comple	Me	29b. Signature and little of certifier	Medical	Houseolla	29c. License 1	number 5748	294. [	Date signed (Month,  Limber, 21	Day, Year)					
	$7_{1,1}$		30 Name and address of person when a COTO SUYNO	o completed cause of	death Mem 23al (Type,		Baltimore	, Mayle	and 212	23					
	Sta Regist		31. Date filed (Month, Day, Year)  DEC 0 2		trar's Signature	g Some	61								

			For State Registrar	State o	f Marylan	d / Depa	artment <i>tificate</i>	of He	ealth a Death	ind M		Reg. No.	004	380	72
	Physicia	an	Decedent's Name (First, Middle,								2. Date of Dea	ath Day	Year	3. Time of De	
	/Medic		WADE L	JONES							NOV	24	2004	2231	М
	Examin	er	4a. Facility Name (If not institution,	•			4b. City, To		Location of			4c. Col	inty of Death		
	Formul		UNIVERSITY OF MI 5. Social Security Number		7. Age (In yrs.		If Under 1	Year	If Under 2	_	8. Date of Birt	h		lace (State or F	oreian
	Funeral Director		215-70-6003 1 M 2 F 47 Yrs. Months Days Hours Min. (Month, Day, Year) May 22, 1957									Coui	place (State or Fi ntry) laryland	g	
	D		Usual Residence of Decedent												
	arylar show	_	10a. State 10b. County	A 1 / A	10c. Cit	y, Town or Lo	cation	Doll	timore				1	0d. Inside City I	
	Be-f	ecto	Maryland	N/A			101 7: 5					10- 04			
	e or 2	ā	10e. Street and Number 4221 Eldone Road				10f. Zip C	ode	2122	9	10g. Citizen of What C			•	
	leath ns 23	Funeral Director	11. Marital Status	12. Was Dece	.S.   13. V	Was Decede	nt of His			cify Yes or No	- 14. [	Race - Americ	an Indian,		
(0	ifter d		1 Never Married 2 Marrie	Armed Fo	2 ☑ No					Puerto	ecify Yes or No- Rican, etc.)		Black, White,	etc.	
<u>Ö</u>	rel', c	1 by	3 Widowed 4 Divorced	If Yes, Giv Year or D	/e ates:		1 ☐ Yes 2 🕅 No Specify:					Spe	ecify:	Black	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Modical Examiner must be modified at	Completed	15. Decedent' (Specify only highes	s Education grade completed)		(Give	dent's Usual kind of work	done du	urina most	of worki	ng	16b. Kind o	f Business/In	dustry	
121	within	ldu	Elementary/Secondary (0-12)	College (1	1-4or 5+)	inte. i	DO NOT use	,	Worke	er		1	Binder Gr	aphics	
2	e filed within al Hygiene. I other then "		17. Father's Name (First, Middle, L	ast)							(First, Middle,	Maiden Sun	name)		
au	ld be ental ked o	To Be		ly Jones							_	nily Jone			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23e or 28e-f show or other treumetic event, Ite Madical Exam per must be notified at	-	19a. Informant's Name/Relationsh	r or Rura	I Route Numbe	ar, City or To	wn, State, Zip	Code)							
	is 1 and 2 of Health a item 27 is other treu		Twilia Jones Sister			52	13 Ivanh	noe Av	ve. Balti	imore,	Maryland	21212			
ore	of He of He fiten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □ Removal from	1 /	Place of Dispo semetery, crer	sition (Name natory or oth	e of er place	)		ate		Oc. Location - City or Town, State		
altimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		' 4 ☐ Donation 5 ☐ Other (Sp	ecify)			Mt. Zio				11/30/04	Lan	dsdown ,	Maryland	
Ball	permit Depar Impor any in		21. Signature of Furniral Service L	icensee		22	. Name and Est				al Home P. altimore, M	.A			
			23a. Part1. Enter the disease, on shock, or heart failure. List	omplications that of	aused the deat	h. Do not ent								Approximate Interval Between	
0,	Physician /Medical Examiner bullet side pe executed bullet side prize transit sthe prize transit sthe prize transit street per side per si	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	ENMON (or as a conseq (or as a conseq (or as a conseq	uence of):								2 WEEK	: 3
.O. Box 68760,	that the death certificate be executed led by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live t	tcome of pregna pirth 2 □ Feta nant at time of c	I death 3	Ectopic pred					23d.	Date of delive	ery Day Yea	ır
rds, P	faw requires tha as been signed 2 should be de	by	Part II. Other significant condition		eath but not res		• -	•				obacco use o res 2 🗆 No		ne cause of deat ably 4 XIUnk	
of Vital Records,	ө <u>г</u> ө	Completed	24a. Was an autopsy performed 1   Yes 2   25									sy	prior to co death?	psy findings ava mpletion of caus	illable se of
ital	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?								(Check only o	ne)			
of V	Physicien: this certific ral director,	2	1 ☐ Yes 2 No			ER/Outpatier					me 5 Resid			y)	
		ion:	27. Manner of Death 1 ♣Natural 5 ☐ Pending	,	of Injury th, Day Year)	28b. Time of Injury	M 28	c. Injury Work	at ? ′es 2.⊟N		28d. Describe h	now injury oc	curred		
Division	tend leath tor: the	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determine	ot be 28e. Place	of Injury - At h	ome, farm, str fy)			95 Z		28f. Location (5 City or Tov		ımber or Rura	l Route Number	r,
	Hospitel 4 hours Funerel iely filled	edical Ce		g Physician: To the Examiner: On the b											
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c.	License	number			29d. Date siç	ned (Month,	Day, Year)	
	->		> MW3	Apris	MD			P18	577			NOV	24	2004	
	Δ		30. Name and address of person	who completed caus	se of death (Iter	n 23a) (Type,					2	25.6	REENE S		
_	<u></u> /			PERT, MI		ERSITY &	FMARY	LAND	MEDIC	CALCE		-	ORE MO		
`	Sta Registi		31. Date filed (Month, Day, Year) DEC 0 2		Registrar's Signa		Spo	als							

State of Maryland / Department of Health and Mental Hygiene 00 14 1 - For State Registrar 38073 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** ANIC 18:10A NOVEMBER 27 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. BALTIMERE INR15 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Days 1 □ M 2 K F Hours Min -14-5856 CHICAG Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other treumatic event, the Madical Examinar must be motified at 1 ☐ Yes 2 No BALTIMORE Directo MNICHOMII 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? VALLE DEN Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "naturel", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FFICE ANUTACIORING 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KORANDA LIRISTINE FRANK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 s it of Health an E BURGH HRISTINE DANGHIE KOEDALE , NO 2123 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. EVALSFOLDER CHAPEL-DELAS 4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service U ensee 04 FORESI Thill 22. Name and Address of Facility EVANS CHASEL HARFORD MD 21234 KARKVILLE. 101220 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 N Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner use as the burial-transit that initiated events resulting in death) Last this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed niaspi 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 200No 1 🗌 Yes 2 ER/Outpatient 3 DOA 1 Inpatient ursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Aatural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A death. 2 Accident investigation 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tive of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15504 1. 29.04. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

10:10

NOVEMBER

ALICE JANICKI

State of Maryland / Department of Health and Mental Hygiene, 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Kimble **Physician** David 19:23PM November 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number UNF 6. Sex Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1**√** M 2□ F Florida Yrs. May 14, 1949 Director 55 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28e-f show the Madical Examiner must be notified at Y☐Yes 2☐No Baltimore Director N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21213 Items 23a 3502 Longview Ave. Be Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify Black 3 ☐ Widowed 4 ☑ Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Home Improvement Elementary/Secondary (0-12) Coilege (1-4or 5+) Carpenter permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: If item 27 is marked other it, any njury or other fraumatic event. Its once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Marie Kimble David Kimble Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3502 Longview Ave. Baltimore, Maryland 21213 Rona Kimble 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Landsdown, Maryland 12/06/04 \* 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion 21. Signal of Funeral Strvice Vice see 22. Name and Address of Facility Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Acute Renal /Medical Due to (or as a consequence of): **Examiner** Septic Shoc Due to (or at a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Il-transit Due to (or as a consequence of): physician ar s the burial-t P.O. Box 68760, Physiclan/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Yes the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2∏ No 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation or Attanding Natural 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attandii within 24 hours after death, To tha Funaral Director: A 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and hitle of certifier RES-000 , Medicine Resident November 28, 2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital 600 North Wolfe Street Bultimore, MD 21287 Ardehali, MD DEC 0 2 2004 32. Registrar's Signature 31. Date filed (Month, State Registrar

State of Maryland / Department of Health and Mental Hygiene 38075 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Ronald Kelley 7:30 A W illiam November 27 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel 8940 Twin Ridge Court 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 4/13/1936 Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 217-30-2633 68 Director MD Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location or 28a-f show the Medical Examiner must be nutified at 1 Yes 2 XNo Director Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8940 Twin Ridge Court "natural", or Items 23a 21061 USA death v by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after dea.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" eny injury or other traumatic account. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, atc. 1 Never Married 2 Married 1□Yes 2₹No 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineering Design Draftsman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William E. Kelley Elizabeth Connolly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8940 Twin Ridge Court, Glen Burnie, Maryland 21061 Geraldine Kelley / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/1/2004 Glen Burnie, Maryland Glen Haven Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. MO1357 Minuser. 1 Second Avenue, SW G1en Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** S /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any landing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be execu Due to (or as a consequence of): Box 68760, physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ funeral director, page 2 should be 15005 1 Yes 2 🗆 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 3 DOA Medical Certification; To 1 Inpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after death uneral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To use.
Within 24 hours...
To the Funeral Direct þ 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who complete r can e of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State 02 DEC 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 1, per, phys. 838 12-8-04 et and Martal Hurian.

			For Stata Ragistrar	State of Marylan		tificate of De			eg. No. 0 0	4 38076
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Dea Month		3. Time of Death
	/Medic	al	ROBERT M. LUTZ	Richard M	I. Lut			NOVEMBE	30, 200	
	Examin	er	4a. Facility Name (If not institution, give 9507 KINGSCROFT TI	,	E	4b. City, Town, or Lo PERRY HA			4c. County of	
	Funeral		5. Social Security Number 6. Se			If Under 1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day	BALTIM	DRE  B. Birthplace (State or Foreign Country)
ь	Director		217-24-1096	M 2□F 76	Yrs.	Months Days H	lours Min.	11/14/	1928 I	MARYLAND
	and w		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Loc	ation				10d. Inside City Limits
	Marylar f show	ō	MD BALTIMON		RY HALI					1 ☐ Yes 2 🛣 No
	the f	rect	10e. Street and Number			10f. Zip Code			0g. Citizen of Wh	at Country?
	ath with 23e of ust be	al Di	9507 KINGSCROFT	TERRACE UNIT	E	21128			USA	
	ems 2	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. W	as Decedent of Hispa Yes, specify Cuban, N	inic Origin? (Spe	ecify Yes or No-	14. Race -	American Indian, White, etc.
36	or lt	by Funeral Director	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give	1	□Yes 2ŽÍNo S		1110411, 010.7	Specify:	
21215-0036	within 72 hours after death with the Maryland nne. Then "neturel", or Items 23a or 28e-f show "a Me Jical Exir illier ir ast be rivillied at	ed b	15. Decedent's Edu	Year or Dates:	16a Decede	int's Usual Occupation			16b. Kind of Busin	WHITE
15	in 72 n "ne nelic	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed)  College (1-4or 5+)	(Give k	ind of work done durir O NOT use retired)	ng most of worki	ing	100. Killa of Basil	nessindustry
212	giene giene ar the	Com	12TH GRADE	College (1-40) 3+)	SURVE	EY ENGINEE	R		BALTIMOF	RE CITY
pu	2 should be filed within and Mental Hygiene. Is marked othar then aumatic evant, IT.∈Ms	Be	17. Father's Name (First, Middle, Last)			18.	. Mother's Name		Maiden Sumame)	
yla	should bind Ment marker marker	۲	DONALD MILTON LUI					E DANDDY		
Maryland	d 2 st th and traun traun		19a. Informant's Name/Relationship (7) VICTORIA LUTZ	WIFE	9507 F	Address (Street and INGSCROFT	TERRACI			ate, Zip Cod <b>2</b> 1128 HALL, MD
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygener. Important: If final 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other traumatic evant, It. Medical Exercitive fraust be rutified at once.		20a. Method of Disposition	20b. Pl	ace of Disposi	tion (Name of			20c. Location - Ci	
E O	Pages ient of nt: If i		1 Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)			atory or other place) NITED METH	12/	3/2004	MONKTON,	MD
Baltimore,	permit. Departm Importa any inju		21. Sign ture of Funeral Service Licens	ee // CHU	RCH CEN	FTERY ame and oddress of	CELLICA.			L HOME, P.A.
Ω			Heather N	· Hayes	8	521 LOCH R	AVEN BLY	VD. TOW	SON. MD	21286
п			23a. Fart1. Enter the disease, or compleshock, or heart failure. List only of	ne cause on each line 4	. Do not enter	the mode of dying, s	uch as cardiac o	r respiratory arre	est,	Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition resulting in death)	& Clobla	stum	od Mul	titor	ME		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):					
		e.		Distriction (or as a consequ	encolof):					
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	The law requires that the death certificate be executed its has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):					
68760,	ate be	edical		1.	_					
	ding p		IF FEMALE:	3c. If yes, outcome of pregnar	201					
Вох	eath cerr attendin for use	Physician/M	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 E	ctopic pregnancy Other (specify)			23d. Date o Month	of delivery Day Year
o.	that the de ed by the detached	Jysi	1  Yes 2  No 9  Unknown	9□ Unknown		Striet (Specify)				
٦,	es that igned b	by PI	Part II. Other significant conditions con	ntributing to death but not resu	lting in the und	lerlying cause given in	Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
rds	w require been sig should b							1 ☐ Ye	s 200 No 3[	☐ Probably 4 ☐ Unknown
Records,	ne law re has be ge 2 sho	Completed						24a. Was ar		re autopsy findings available r to completion of cause of
	The I	Соп						perforg	ed? dea	th? Yes 2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Other		(Check only one		
of	Physithis ral dii	- To	1 Yes 2 No	1   Inpatient 2   E	28b. Time of	3☐ DOA 28c. Injury at			nce 6 Other (	(Specify)
O	th. : After s funer	itlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work?	2 🗆 No		wanjary ooddiroo	
Division	or Attanding Ph	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stree	ot, factory, office	2	8f. Location (Str City or Town	eet and Number of	or Rural Route Number,
Ō	tal or rs afte el Dir ed in	Cert	T TOMOGO	building, etc. (Specily,	,			City of Town	State)	
	To tha Hospital or Attanding within 24 hours after death.  To tha Funarel Director: After completely filled in by the fune.	Medical	(Greck only 2 Madical Exami	sician: To the best of my knownar: On the basis of examinati	vledge, death o ion and/or inve	occurred at the time, distinguished	late and place, a n, death occurre	and due to the ca	use(s) and manne te and place, and	er as stated. due to the cause(s)
	thin 2 thin 2 tha omple	Med	one)  29b. Signature and title of certifier A	and manner stated.		29c. License nui			d. Date signed (A	
	⊢ ≱ <b>⊢</b> δ		Day Duich	etoma el		013	272		12-	1-04
	0/1		30. Name and address of person who co	impleted cause of death (Item	23a) (Type, Pr	rint)		2	A /	
`	10.		30. Name and address of person who co	Robert 12. Sto	mer MD	Juite 403	7505	Oslev	BUINE	Los La
			31. Date filed (Month, Day, Year)	32. Registrar's Signation 2004		5 Som				

				pe of Fine in Di				_	
			1 - State Registrar	State of Maryland	Certificate		lental Hygler Reg. N	71114	38077
			Decedent's Name (First, Middle, Last)	, ,	0		2. Date of Death		3. Time of Death
	Physici /Medic		Helen Hott.	ses Lora	<u> </u>			er 28,200	
	Examin	er	4a. Fecility Name (If not institution, give str	1011	4b. City, Town	n, or Location of Death	0	4c. County of Deat	1 County
	Funeral		5. Social Security Number 6. Sex	7. Age (In As. las	t birthday) If Under 1 Ye		8. Date of Birth (Month, Day, Yee	9. Birth	hplace (State or Foreign untry)
	Director		21101111	20 107	Yrs. Months Da	ys Hours Min.	April 25, 1	897 Wa	Tham MA.
	land		Usual Residence of Decedent  10a. State , 10b. County		Town or Location				10d. Inside City Limits
	Mary Pefsh	tor	Maryland Carrol	1 Co. h	restmins	ter			1 ☐ Yes 2 No
	n 72 hours after death with the Maryland "naturel", or Items 23a or 28e-f show salical Examiner must be notified at	Director	10e. Street and Number	Circle	10f. Zip Cod	1158	10g. C	Citizen of What Co	untry?
	seath v	Funerai	11. Marital Status 12	Was Decedent Ever in U.S.			ecity Yes or No-	14. Race - Amer	ncan Indian,
٥	after or ite		1 Never Married 2 Marned	Armed Forces?  1 Yes 2 No	If Yes, specify C	of Hispanic Origin? (Spe Juban, Mexican, Puerto No Specify:	Rican, etc.)	Black, White	e, etc.
- - - - - - - - - - - - - - - - - - -	hours turs!,	ed by	3 Widowed 4 □ Divorced  15. Decedent's Educa	If Yes, Give Year or Dates:	16a. Decedent's Usual Oc		16h	Kind of Business/I	nire
<u>.</u>	within 72 ene. then "ne	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work do life. DO NOT use re	ne during most of worki tired)	ng	-	Hospital
7	filed with Hygiene other the	Com	12		Nursa				110spisal
aua	d be fil	o Be	17. Father's Name (First, Middle, Last)	es Hoff	res	18. Mother's Name	(First, Middle, Maide	In Sumame)	
ary	shoul and Me amark umari	오	19a. Informant's Name/Relationship (Type		19b. Mailing Address (Str	eet and Number or Rura	I Route Number, City	or Town, State, Z	lip Code)
E, E	and 2 ealth a m 27 Is		Mrs. Patricia St	picer	813 Dunk	rook Ct	. Freder	- / -	0.21701
	Pages 1 and of He of Herral II II Item		20a. Method of Disposition  Burial 2 ☐ Cremation 3 ☐ Ren		e of Disposition (Name of etery, crematory or other	olace) / No	V. 30, 20c.	Location - City or 1	Town, State
Baitin	nit. artm orts inju	. 3	*4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fuperal Service Licensee	Dair	22 Name and Ad	Pless, of Facility /	2004	C - 20	als vamed
ñ	Depa Impo any is	1	Jeffrey 7	· fank	r Peacet	4/70-KR	d. Tim	num	MD. 21093
	let -		23a. Parh. Enter the disease, or complica shock, or heart failule. List only one	tions that caused the death. I cause on each line.	Do not enter the mode of	dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequen	separs				
	Examiner		Convention the liest accorditions to the	Hene	unat re	ma			
	pe tis	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequen	nce of):				
	axecute al-tran	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequen	nce of):				
700	eath certificate be executed attending physicien and for use as the burial-transit	cai	d						
X OX	certifica Iding ph Ise as th	Physician/Med	IF FEMALE:	M					
DOX	eath c attend	cian/	in the past 12 months?	If yes, outcome of pregnancy  1 Live birth 2 Fetal de  4 Pregnant at time of deat	ath 3 Ectopic pregna			23d. Date of delin	very Day Year
j.	to the d	hysi	1  Yes 2  Pivo 9 Unknown	9 Unknown					
12,	w requires that the death been signed by the atter should be detached for u	by	Part II. Other significant conditions contri	buting to death but not resulting	ng in the underlying cause	given in Part I.			the cause of death?
cords		eted	17 year 170 Was	346		<u> </u>	24a. Was an		
ď١	8 8 8	Completed					autopsy performed?	prior to co	oppsy findings available ompletion of cause of
VII	ctor, p	BeC	25. Was case referred to medical examiner?			26. Place of Death	(Check only one)	, 10 193	2   NO
5	Physic this co	2	1 ☐ Yes 20 No Hos	pital: 1 ☐ Inpatient 2 ☐ ER 28a. Date of Injury 28	Outpatient 3 DOA		ne 5 Residence		ify)
0	nding tth. :: After e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury V	Vork?	soci Describe flow inj	ary occurred	
DIVISION	r Atte	Certification:	2 Cuiside 6 Could not be	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, offic	Ce 2	28f. Location (Street a City or Town, Sta		ral Route Number,
2	pital o		29a Certifier LCertifying Physic	ion. To the board To be and					
	To the Hospital or Attending Physician: The I within 2 Hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edicai	(Check only one)	ian: To the best of my knowle : On the basis of examination and manner stated.	a and/or investigation, in m	s time, date and place, a ly opinion, death occurre	and due to the cause( ad at the time, date ar	s) and manner as and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	///	29c. Lice	ense number	29d. D	ate signed (Month,	, Dey, Year)
	Ų.		• ( //	all	West 1)	37949	No	J 29th	2002
	1/		30. Name and address of person who comp	olered cause of death (Item 23	01	. Almin.	11.0	1 2gram	211ST
	Sta		31. Date filed (Month, Park Ynar) ? ? ? ?	32. Registrar's Signature	19 600	eks)	mer	CIVILLE	CV ( VV)
	Registr	ar	MEG AN ECO	1	J				

	1 - For State Registrar  1. Decedent's Name	(First Middle 1	a st)		Cei	rtificate of	Death	125	Reg.	N200	) l <sub>4</sub>	3807
cian	I EONA DI							l N	ate of Death Ionth CEMBER	Day	Year	3. Time of Deat
ical iner				mber)		4b. City, Town,	or Location of			4c. County		11:20 A
	STELLA M	ARIS HOS	SPICE			TIMON	EUM			BALTI	MORE	
	5. Social Security Nur		Sex 1 □ M 2 12x1 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 2	4 Hrs. 8. D. Min. (A	ate of Birth fonth, Pay, Ye 25/193			ace (State or Fore
	229-36-656 Usual Residence of D	67		73	TIS.			8/	25/193	1	VIRG.	INIA
	10a. State	10b. County	<u> </u>	10c. C	ity, Town or Lo	cation					10	d. Inside City Lin
ctor	MD	BALTIMO	ORE	1	PARKVIL	LE						1 ☐ Yes 2 🛣
Director	10e. Street and Numb		4.5			10f. Zip Code			10g.	Citizen of W	/hat Count	ry?
Funeral	1524 DAY	TONA ROA		edent Ever in I	IS 13 V	212		in? (Specify )	'es or No-	USA 14 Bace	- America	an Indian
핊	1 Never Married	d 2 Married	1 ☐ Yes	edent Ever in U rces? 2 📉 No		Was Decedent of f Yes, specify Cu		Puerto Rican	, etc.)	Black	k, White, e	etc.
Q P		Divorced	If Yes, Gi Year or D	/e ates:		1□Yes 2XIN				Specify:	WH.	ITE
Completed	(Specify	<ol> <li>Decedent's Exposition</li> <li>Only highest gr</li> </ol>	ducation rade completed)		16a. Deced	dent's Usual Occi kind of work don DO NOT use retir	upation e during most o	of working	166	o. Kind of Bu	siness/Ind	ustry
dmo	Elementary/Second		College (	I-4or 5+)			<i>60)</i>			DOI# T1		
Be C			it)		UA.S	HIER	18. Mother	's Name (Firs	t, Middle, Mai	BOWLIN den Sumame		1E2
To B		CATUR MO	CGHEE				MYRT	LE ETH	EL WIL	SON		
	19a. Informant's Nam	·				ng Address (Stree					State, Zip	Code)
	MARVIN C.		HU	SBAND		DAYTONA sition (Name of	ROAD	PARKV Date	ILLE,			un Ctata
	1 XBurial 2 🗌	Cremation 3		State DUI	CANEY Cred	ALLEY ME		2/6/20		. Location - (  OCKEYS		
	* 4 □ Donation 5				1 22	GARDE . Name and Add	'N2-		_			
	M-	Noal	Colon		102	521 LOCE	- FERRISCS	ILE O		FUNER ON, MD		OME, P.A
	23a. Part1. Enter the	disease or con	nplications that	aused the dea								Approximate Interval Between
	Immediate Cause (Fi				ייים ווכיייביי	D PULMON	IADV DT	CFACE				Onset and Death
ı	resulting in death)	-		or as a conse		D FULMON	AKI DI	SEASE_				
-	Sequentially list cond if any, leading to imm	ditions,	b. Due to	or as a consec	ananaa aft:							
nine	cause. Enter Underly Cause (Disease or in that initiated events	/ing	Due to	OF AS A CONSE	querice or):							
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edi	IF FEMALE: 23b. Was decedent p		23c. If yes, ou	irth 2 🗆 Feta	aldeath 3□	Ectopic pregnan	су			1	of deliver	•
edi	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 M i 9 ☐ Unknown	ionths?	23c. If yes, ou	irth 2 ☐ Feta ant at time of o	aldeath 3□	Ectopic pregnan	су			23d. Date Mon		y Day Year
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11:20 а.ш.

**DECEMBER 1, 2004** 

LEONA MOORE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
Amend 11em 8 per fn 3246 8-9-05 vt.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey **Physician** Morgan TOMN 4:00 An ovember 29 2004 /Medical 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Locetion of Death 4c. County of Death Examiner timore VURSIN BALTIMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours **№** М 2 Б Director 218-22-9909 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23s or 28s-f show 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examirer must be noritied at 10d. Inside City Limits MD BALTIMORE 1 ☐ Yes 2 ☑ No Funeral Director PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8650 ROCK OAK ROAD 2.12.34

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) ISA 14. Race - American Indian. 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify. Completed by 3 Widowed 4 Divorced Year or Dates: WWII WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MD BOLT & NATIONAL CO Elementary/Secondary (0-12) College (1-4or 5+) INDUSTRIAL SALESMAN 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MICHAEL LEO MORGAN PEARL HYSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNE M. MORGAN WIFE 8650 ROCK OAK ROAD other t BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: if its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State DULANEY VALLEY MEM. GAR. 12/2/04 Cockeysville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signatur of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence Examiner eta has been signed by the attending physician and paga 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical Due to (or as a consequence of) Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to tha cause of death? 1 Yea 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificeta has 11 TYes 2 WING 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: fillad in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No Director: After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No daath. 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 200

State

Registrar

MD 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEC 0 2 2004

31. Date filed (Month, Day, Year)

60

32. Registrar's Signature

			1 - For State Registrar	State of Marylan	d / Depa		lealth and M	ental Hygi	ene 2001.	320ec
			Decedent's Name (First, Middle, Last	<u> </u>		incate or i	Dealit	2. Date of Death	g. No. 5-4 U U 4	3. Time of Death
	Physic		SADIE LOUISE MO	RELAND				Month	Day Year	M
	/Medi Exami		4a. Facility Name (If not institution, give		ì	4b. City, Town, or	r Location of Death	Novembe	r 25,2004 4c. County of Death	0407 A <sup>™</sup>
			Sacred Hear	t Hospital	\	Cumb	erland		Allega	
	Funeral		Social Security Number     6. Se	TM 0535		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )		place (State or Foreign ntry)
	Director		234-40-2853	□M 2 🟋 F 87	Yrs.			January		st Virginia
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary 1 sh	ğ	MD Allegan	v Rat	vlings					1 ☐ Yes 2 ☑ No
	r 28a	irec	10e. Street and Number	J		10f. Zip Code		100	g. Citizen of What Cou	
	th witi	Funeral Director	19851 Deep Holl	ow Road, S.W.		2155	7		USA	•
	ems ems	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \		ispanic Origin? (Spec in, Mexican, Puerto F	cify Yes or No-	14. Race - Ameri	
98	or It	J.F.	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 No If Yes, Give	i	☐ Yes 2 🛣 No		rican, etc./	Black, White,	etc.
8	within 72 hours atter death with the Maryland sine. than "naturel", or items 23e or 28a-1 show item Madical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:						ite
21215-0036	"nat	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deced	lent's Usual Occupa kind of work done of	ation during most of workin I)	9 16	3b. Kind of Business/Ir	dustry
12	filed withi Hygiene. other than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		rse's Aid	•		Hospita	1
b	illed Hygie other ent.	Φ	17. Father's Name (First, Middle, Last)	<u> </u>	110.	isc s Alu	18. Mother's Name	(First, Middle, Ma		<u> </u>
a	ould be Mental arked o	To B	Martin Sherman	Walker			Phidot1	na Fave	Riggleman	
Maryland	2 should be and Mental le marked damatic ev		19a. Informant's Name/Relationship (T)		19b. Mailin	g Address (Street a			City or Town, State, Zip	Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 Ie marked other than "neturel", or Items 23e or 28e-f show other traumatic event. The Medical Examiner must be notified at		Oliver K. Morelan	d, Jr./Husband	1 198	351 Deep	Hollow Roa	ad, S.W.	Rawlings	, MD 21557
ore	ot He fitem		20a. Method of Disposition	20b. Pl	ace of Dispos	sition (Name of natory or other place	a)		c. Location - City or To	own, State
Ë	ortment of Portion of	1	1 Magazia 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)	removal from State	•	emorial G	No.	v. 28 004	Keyser, W	V
Baltimore,	permit. Page Deportment of Important: If any injury or once.		21. Signature of Funeral Service Licens	98	22	Name and Addres			ral Home	
	20 2 2 9	8 15	Brian F	frith		85 S. Ma	in Street	Keyser	, WV 2672	6
	death certificate be executed  Medical  Examiner  of for use as the burial-transit	cai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and additional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ence of):	my Dis	feration			Onset and Death I houre
P.O. Box 68	that the death certificat led by the attending phy detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal ( 4 □ Pregnant at time of decent of the second of the sec	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
<u>s</u> , Б	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions cor	ntributing to death but not resul				23e. Did tobac	cco use contribute to the	e cause of death?
ğ	w require been sig should b		Trabetes m	ricletus :	Ren	al Fra	ufficiency	1 🗆 Yes	2 □ No 3 □ Prob	ably 4 Minknown
Record	e law requ has been je 2 shouli	Completed		/			1.	24a. Was an	24b. Were auto	psy findings available
<u> </u>	9 2 9	mo;						autopsy	d? prior to cor death?	npletion of cause of
Vital	elcien: In certiticate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Death (	1 Yes 2 Check only one)	patro   1 mas	2 110
o t	=	7	1 ☐ Yes 2 ☐ <del>Mo</del>	lospital: 1   Inpatient 2	R/Outpatient	3□ DOA Othe	r: 4 Nursing Home	e 5 ☐ Residenc	e 6 Other (Specify	·)
	th. : After this funeral o	on:	27. Manner of Death  1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 28	d. Describe how	injury occurred	
Sio	Attending is death. ector: Alter by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be			M 1 7	'es 2□No			
Division	To the Hospitel of Attend within 24 hours after death To the Funerel Director: completely filled in by the f	Certification;	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)				City or Town, S		
	vithin 24 hours after To the Funerel Director Completely filled in bi	edical	29a. Certifier   Table Certifying Physical (Check only one)   2   Medical Examination   1   1   1   1   1   1   1   1   1	sicien: To the best of my know ner: On the basis of examination and manner stated.	rledge, death on and/or invi	occurred at the time estigation, in my op	e, date and place, an inion, death occurred	d due to the caus at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
i	To t Com	Σ	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month, I	Day, Year)
ļ.	1		Con	/ )		72	1244	N	November 2	6 2004
	5		30. Name and address of person who co	mpleted cause of death (Item :	23a) (Type, P	rint)		10.0		
			Dr. Jesus Ian,	Route #36, F		13 Plas	a, Frostb	and WID	21532	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu		1	2.7			

DHMH 17 Rev 1/2001

ORIGINAL

		e-3.	1 - Stete Registrer  1. Decedent's Name (First, Middle, Last)	State of Mary	land / Depa <i>Cei</i>	artment of F	lealth and I Death		eg. No.	38081
Žį.	Physici /Medic	cal	Ruth  4a. Facility Name (If not institution, give s	M	1ekolon	dh Chi T	- Landin	Novembe	r 29, 200	4 9:15 P M
	Examir	er	1745 Stengel Avenu			Dundalk	Location of Death	1	4c. County of De Baltim	
	. Funeral Director		220-22-9057	7. Age (In	yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 11	, 1916 9. B	hirthplace (State or Foreign Country)  MD.
	nyland how	_	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo					10d. Inside City Limits
	the Ma 28e-f s	ecto	MD. Baltimor  10e. Street and Number	е	Dundalk	10f. Zip Code			0g. Citizen of What (	1 ☐ Yes 2 No
	th with 23s or	al Dir	1745 Stengel Avenu	e		2122	22		USA	Country ?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other then "naturel", or Items 23a or 28e-f show apply injury or other treumetic event, it is Medical Exalt in the realitied at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ※ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	l1	Vas Decedent of H Yes, specify Cuba □ Yes 2X No	ispanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	Black, Wh	nerican Indian, hite, etc. hite
2-00	72 hou nature	Completed by	15. Decedent's Edu (Specify only highest grade	cation	(Give	lent's Usual Occupa	during most of wor	kina	16b. Kind of Busines	
21215-0036	l within jene.	ompl	Elementary/Secondary (0-12) 7 years	College (1-4or 5+)	life. L	OO NOT use retired usewife	)		Own Home	
	be filed tal Hygie d other i	Be	17. Father's Name (First, Middle, Last)		110	asewire		ne (First, Middle, M	Maiden Sumame)	
Maryland	should nd Men marke imetic	2	Michael Brodowski  19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailin	g Address (Street a		Valitsk	O City or Town, State.	Zin Codel
	is 1 and 2 of Health ar item 27 Is other treu		Jacob Mekolon Jr.	Son	11820	Gum Poi	nt Road,			
altimore,	Pages 1 nent of H ent: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	amovar nom otata	Ob. Place of Dispos cemetery, crem			mber	20c. Location - City of Dundalk, M	
altir	permit. F Departme Importen eny injur		21. Signature of Fyneral Service License		hrist Lu				undalk,P.	
m m	20159	2 Hi	23a. Párt 1. Enter the disease of complishock, or heart failure. Ust only or	cations that caused the	Melly	110 SOTTE	ers Point	Road, D	undalk, Mu	21222 Approximate
€ €	Prrysician /Medical Examiner		shock, or heart failure. Lift only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	obstract					Interval Between Onset and Death
V,	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
P.O. Box 68/60,	ath certil ittending or use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	20 20 20 10		23d. Date of do	elivery Day Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con	tributing to death but no	t resulting in the un	derlying cause give	n in Part I.			to the cause of death?  Probably 4 @Unknown
Division of Vital Records,		Completed			· · · · · · · · · · · · · · · · · · ·			24a. Was ar autopsy perform 1 Yes 2	prior to ed? death?	autopsy findings available completion of cause of s
VIta	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?  1 □ Yes 2 No	ospital:	• T-FP(0 + + + + + + + + + + + + + + + + + + +	Othe		h (Check only one	/	
lon of	ding Ph h. After th funeral	atlon; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	4 □ Nursing Ho at ? /es 2 □ No	28d. Describe ho	nce 6 Other (Sp. w injury occurred	ecify)
DIVIS	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
	Hospi 24 hour Funer stely fill	edical	29a. Certifier 1 Certifying Phys (Check only one)	icien: To the best of my ter: On the basis of exa- and manner stated.	knowledge, death mination and/or inv	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier  R. Sapala Me			29c. License	number 1895(		d. Date signed (Mon	
	6		30. Name and address of person who con		(Item 23a) (Type, F	Print)			/	704 Z1224
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature		Social.		1-2 20.4	704 2.65(

State of Maryland / Department of Health and Mental Hygienes 38082 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** DAVID MAGILL NOV 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** UNION MEMORIAL HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **XX**M 2□ F Days Hours Min. Yrs. 204-12-3030 Director 80 AUG. 6,1924 PENNSYLVANIA Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner must be notified at 1XXes 2 No Director N/A MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 3510 NOBLE STREET 21224 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 U No If Yes, Give Year or Dates: 1943-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.
is marked other then "neturel, or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: 3 X Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) IRONWORKER STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PAUL MAGILL BLANCHE HARMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Importent: if item 27 is eny injury or other treu once. 19 S. CONKLING STREET, BALTIMORE, MD. 21224 PAULA MAGILL/ DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State CROWNSVILLE VETERANS 12/03/04 CROWNSVILLE, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
700 S. CONKLING STREET, BALTO., MD. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardia disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed. burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à should be 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 2 2 No 1 ☐ Yes 1 🗌 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner 1 X Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of Certification: Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide hours after within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0061369 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Hemoria 32. Registrar's Signature 31. Date filed (Month. State Registrar

	07462		Please Type or I  For Unpend Item 23a, 27, 27  Registrar  Production Name (First Middle Least)	Maryland/Dep	idelible Ink. aggent <u>2<sup>f</sup> 2</u> ortificate of	teatth and M	ental Hygi	ene 0 0 4	38083
	Physicia		Decedent's Name (First, Middle, Last)     Shaw	n McGill Ma	yers		2. Date of Death Month November	Day Year	3. Time of Death 10:47p M
	/Medic Examin		4a. Facility Name (If not institution, give street and num			r Location of Death		4c. County of Death	
			2717 Round Road	- 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	Baltime		0.5-1-1.5		
	Funeral Director		5. Social Security Number  216-80-2415  Usual Residence of Decedent	7. Age (In yrs. last birthday, 43 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Apr 17, 1	9. Birth 961 N	place (State or Foreign intry) laryland
	a-f show	ctor	10a. State 10b. County  Maryland N/A	10c. City, Town or L		ltimore			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
4	m with the 23a or 28 st be no	al Director	10e. Street and Number 2717 Round Road		10f. Zip Code	21225	10	g. Citizen of What Co U.S.A	•
036	Z should be lied within 72 hours after death with the maryland and Mental Hygiene. Is marked other then "natural", or items 23s or 28s-f show aumatic event, the Modical Examinational terminist and	by Funeral	11. Marital Status  1 Never Married  2 Married  1 Never Married  2 Narried  1 Yes, Giv  Year or Di	rces? 21/21 No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
Maryland 21215-0036	within 72 no jene. r then "natur Ine Medical.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1	(Give	DO NOT use retired	during most of worki	ng 1	6b. Kind of Business/l Baltimoi	-
land	uld be filed Mental Hyg irked other itic event,	To Be C	17. Father's Name (First, Middle, Last)  David Mayers			18. Mother's Name		aiden Sumame) te Weems	
Mar	12 Sh h and h and 7 is m traum	•	19a. Informant's Name/Relationship ( <i>Type</i> , <i>Print</i> )  Tangina Mayers Wife			and Number or Rura pad Baltimore,		City or Town, State, Z 1225	ip Code)
Baltimore,	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other 2002.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place Mt. Zion	ce)	1/27/04	Co. Location - City or Landsdown	to the same of the
Bait	Departr Departr Importe any inju		21. Signature of Funeral Service Licensee	b	1300 Eu	rothers Funera Itaw Place Ba	Itimore, MU	21217	
E	Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequence of):		ng, such as cardiac c	r respiratory arres	st,	Approximate Interval Between Onset and Death
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medical Ex	d	ant at time of death 5	□Ectopic pregnanc; □ Other (specify) _	,		23d. Date of delik	very Day Year
rds, P	quires that the de on signed by the uld be detached		Part II. Other significant conditions contributing to de	eath but not resulting in the	underlying cause giv	ren in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Vital Records,	: The law requir cate has been si page 2 should	Completed					24a. Was an autopsy perform 1 Yes 2	prior to c	opsy findings available ompletion of cause of 2 No
\ Kita Kita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?  Hospital:	0.758.0	Oth	26. Place of Death			ify) At Scene
ion of	ding Ph h. After th funeral	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  Township	Inpatient 2 ER/Outpatie of Injury th, Day Year) -04  ER/Outpatie 28b. Time Found 10:30	of 28c Injur	4   Industrig Hor		ice XXOther (Spec vinjury occurred un	
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 X Could not be determined 28e. Place buildi	of Injury - At home, farm, s ng, etc. <i>(Specify)</i> 1 at home			28f. Location (Stre City or Town, rooklyn,	eet and Number or Ru State) <b>2717 Ro</b> <b>Md</b>	al Route Number, und Rd .
	the Hospite in 24 hours the Funeral pletely filled	ledicai			nvestigation, in my o	ppinion, death occurr	ed at the time, dat	e and place, and due	to the cause(s)
	To the Northin 2.  To the Complete	×	29b. Signature and title of certifier  Working The U	Cull My	29c. Licens			d. Date signed (Month	
				20th		nn Street,	, Baltim	ore, Maryl	and 21201
	Sta Regist		31. Date filed (Month, Day, Year) 32. F	gistrar's Signature	ports				

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar		epartment of Health and Certificate of Death	Mental Hygie		38084
Ī	Physici /Medic		1. Decedent's Name (First, Middle, Last	ne Mille		2. Date of Death Month	Day Yeer	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give 128 Green 1765. Social Security Number 6. Security Number 15. Social Security Number	neadow Drive	Months Days Hours Mir	'S. 8. Date of Birth	4c. County of Dea Ballym 9. Bin 125 Ba	ith  OCE CO :  thiplace (State or Foreign output)  Himore, ML
	Maryland -f show	tor	Usuel Residence of Decedent  10a. State 10b. County  RAIT	MORE 10c. City, Town	or Location im ONIUM	10011 171		10d. Inside City Limits 1 ☐ Yes 2 1 No
	th with the 23a or 28a unt be nutif	rai Director	10e. Street and Number 128 Green M	eadow Dive.	10f. Zip Code 21093	10g.	Citizen of What Co	puntry?
036	filed within 72 hours after desth with the Maryland Hygiene. wher then "netural", or items 23e or 28e-f show with the Medical Examiner: stat be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes, 2 No If Yes, Give Year or Dates:	<ul><li>13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue</li><li>1 ☐ Yes 22 No Specify:</li></ul>	Specify Yes or No- irto Rican, etc.)	14. Race - Ame Black, Whit Specify: U	
1215-0	within 72 ho ene. then "netur he Madical I	Completed	15. Decedent's Edu (Specify only highest grad	e completed)  College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of wife. DO NOT use retired)	orking 16b	Kind of Business	/Industry
Maryland 21215-0036	should be filed ind Mental Hygi marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) William J	. Gauss.	Mar	ame (First, Middle, Maid	no Gou	can an
Baltimore, Mar	Pages 1 and 2 nent of Health a ant: If item 27 is arry or other tra		19a. Informant's Name/Relationship (T)  20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	IER - dau . 20b. Place of E cometery, Dilang		Date 200	Laurel Location - City or	M.D. 26707 Town, State n. M.D.
	Physician   Physic		23a. Part1. Enter the disease or compor shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	of Suporthy	t enter the mode of dying, such as cardia	ATIVES FUL	STIMONI DERALYCI	COMMATION Approximate Interval Between Onsel and Death
8760,	physician and must sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)				
O. Box 6	ath certif ttending or use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
Records, P.	w requires that the de been signed by the a should be detached t	ted by Pl	Part II. Other significant conditions cor	ntributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacc	1/	the cause of death?
_		e Completed	OF Western started and the			24a. Was an autopsy performed 1 Yes 2 2	prior to death?	topsy findings available completion of cause of 2 No
Division of Vital	ding Phys 1. After this funeral di	Certification: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 ER/Outp.  28a. Date of Injury (Month, Day Yeer) 28b. Tim	atient 3 DOA Cther: 4 Nursing I	eath (Check only one)  Home 5 A Residence  28d. Describe how in		cify)
DİVİ	i Pite		3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	i, street, factory, office leath occurred at the time, date and place	28f. Location (Street City or Town, Sta	ate)	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examir one)  29b. Sign füre and title of certifier	ner: On the basis of examination and/o and manner stated.	pearr occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time	urred at the time, date a	(s) and manner as and place, and due Date signed (Month	to the cause(s)
•	$\sigma_{l}$		30. Name and address of person who co	mpjet stause of death (Item 23a) (Ty	D309/0	11/	29/04	
100	Sta Registr	15-	11. C. S. P. S. F. J. 31. Date filed (Month, Day, Year)	32. Registrar's Signature  Bancoa	Gerk Red. Lu G Sparks	Therville	MD.	21093
DH	MH 17 Rev 1/20	01	ALP A C	104				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #10b PER FH G838 Gentificate of Death 04 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20 A.M orraine JO V /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ず Mari HOS DICO lla SALTIMORE imoniu If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 9. Birthplace (State or Foreign Country) MARYLAND Funeral Date of Birth (Month, Day, Year) 108 1 □ M 2 F Months Days Hours Min Yrs. 215-34-829 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MN Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21239 Ave Items 23a 1120 JSA. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after i Hygiene. 1 Never Married 2 Married 0 1 Yes 2 No Specify: White Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Ker Omema 11 17. Father's Name (First, Middle, Last) 48. Mother's Name (First, Middle, Maiden Sumame) Be Dowen urtis Marga ret 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To Date 20c. Location - City or Town, State MD a 1239 1120 Elban Baltimore, 20a. Method of Disposition

1 Surial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ö THUMORE MD 112-2-04 injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address Facility BALT MORE, MD 21234 RUPST EVANS FUNERAL CHAPEL 8800 HARFORD RA complications that caused the 23a. Part1. Enter the disease, of shock, or heart failure. List death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** PANCREATIC CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760 Physician/Medical the Box IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Vital 1 ☐ Yes 2 **X** No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 No her (Specify) HOSPICE this o 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 XNatural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier wit. D43725 Û

DHMH 17 Rev 1/2001

Registrar

28,

NOVEMBER

ANN LORRAINE MITCHELL

Docks

2300 DULANEY VALLEY RD.

32. Registrar's Signature

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

DEC 02 2004

Amend item#5, per Inf, G838, 12/6/04 TI
State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CHARLES F. MONROE NOVEMBER 24, 2004 6:10p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death SEVERNA PARK Examiner ANNE ARUNDEL If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 M 2□ F MARYLAND 63 1 - 20 - 1941Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show ust be notified at MD. ANNE ARUNDEL SEVERNA PARK 1 XYes 2 No Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 111 PINE VIEW AVE. 21146 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status event, the Medical Examiner of Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ◯XNo Specify Specify: BLACK 3 Widowed 4 Divorced Year or Dates: naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) -11--0-TECHNICIAN COOLER SERVICE COCA COLA BOTTLING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I ent: If item 27 Is marked of THOMAS MONROE CARRIE PACK ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNICE E. MONROE (WIFE) 111 PINE VIEW AVE. SEVERNA PARK, MARYLAND 21146 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages to Department of the Importent: If ite any injury or ot ASBURY TOWN NECK CHURCH CEMETERY 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-30-2004 | SEVERNA PARK, MARYLAND 22. Name and Address of Facility WM. REESE & SONS MORTUARY P.A. 21. Signature of Funeral Service Licensee LARRY REESE Lavry H. Leese MO0483 821-WEST ST. ANNAPOLIS, MARYLAND 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cascing Liver /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): burial-t Box 68760 sician Physician/Medical the phys as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>م</u> 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performe certificate ha irector, page 2 1 Yes 2/1/No To the Hospital or Attending Physician: Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examine 2 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 25 No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death | Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a rtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)  $\mathcal{O}$ 30. are and address of person who completed gause of death (Item 23a) (Type, Print) went o DEC 02 31. Date filed (Mo 32. Registrar's Signature State 2004 Densus Registrar

07014	1- For Unpend Item Registrar Amend Ite	State of Maryland / Dep. 23a,27,28a-f per me	artment of Health and G838 12-7-04 tas rtificate of Death G83	Mental Hygier	2004 38087
Physician	1. Decedent's Name (First, Middle, Regina McIntosh	•			3. Time of Death
/Medical Examiner	Regina Heritosii		4b. City, Town, or Location of Dea	November 2	26, 2004 7:34 P <sup>M</sup> Ic. County of Death
Lxamiller	Bon Secours Ho		Baltimore		N/A
Funeral		Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hr Months Days Hours Mir	(Month, Day, Yea	9. Birthplace (State or Foreign
Director	213-82-0291 Usual Residence of Decedent	41		01-20-196	3 Maryland
how	10a. State 10b. County	10c. City, Town or Le	ocation		10d. Inside City Limits
with the Mar s or 28a-f sh be notified	Md N/A	Baltimo	T		1 Yes 2 No
a or 2	10e. Street and Number	- Characa	10f. Zip Code 21223		Citizen of What Country?
6 ufter death v r items 23a rither must.	1830 W. Frankli		Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue		S · A ·
after or Ite	1€ Never Married 2 Married	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☐ No Specify:	rto Rican, etc.)	Black, White, etc.
21215-0036 bd within 72 hours after death with the Maryland glene. er than "neturel", or Items 23s or 28s-f show , the Modeal Expression of the notified at Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1	Specify: Black
21215-00 led within 72 hou ygiene. ner than "neture nt, tre Model et Completed	15. Decedent's (Specify only highest	grade completed) (Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking 16b.	Kind of Business/Industry
d 2121 filed within Hygiene. ther than " int, Ire M.	Elementary/Secondary (0-12)	College (1-4or 5+)	omemaker		Housewife
be file that Hy od oth event	, 17. Father's Name (First, Middle, La	ist)	18. Mother's Na	ame (First, Middle, Maide	en Sumame)
aryla should I and Meni a marke umatic	Robert McIntos  19a. Informant's Name/Relationship		Barbara ng Address (Street and Number or F		Town Chair To Code
Ma nd 2 s ulth an 27 Is 1	Barbara Raigns			Columbia, Ma	
ore, Mass 1 and 2 of Health a printer 27 is rother train	20a. Method of Disposition	20b. Place of Dispo			Location - City or Town, State
Baltimore, Maryland sernit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked oth may highly or other traumatic event pice. To Be C	1 Burial 2 Cremation 3	city) Mount Zi	on   12-0	02-2004 Ba	ltimore, Maryland
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show any highty or other traumatic event, the Mudical Examination was the notified at 2016.	21. Signature of Funeral Service Lin		2. Name and Address of Facilit Wi		
	23a. Part1. Enter the disease, or co	emplications that caused the death. Do not en		The second secon	more, Maryland 21229  Approximate
Physician /Medical Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions	a. COCAINE INTOXICATI  Due to (or as a consequence of):	ON AND ETHANOL U	SE	Interval Setween Onset and Death
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vision of Vital Records, P.O. Box 6876( Attending Physician: The law requires that the death certificate be reach. sector: After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the but iffication: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	Part II. Other significant conditions  ASTHMA	s contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Division of Vital Records, or Attending Physician: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death 1 les 2 \(\sumeq\) No
of Vita hysician his certifi al director		Hospital: 1 ☐ Inpatient 2 🔏 ER/Outpatien	Other	ath Check onl one Home 5 ☐ Residence	6 Flother (County)
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Divisic  To the Hospital or Attent within 24 hours after deall To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier 1 Certifying (Check only one) 1 Medicel Ex	Physicien: To the best of my knowledge, death aminer: On the basis of examination and/or in and manner stated.	occurred at the time, date and place	e, and due to the cause( urred at the time, date an	s) and manner as stated
To the within To the comp	29b. Signature and title of certifier	1	29c. License number	29d. D	ate signed (Month, Day, Year)
	Bertin	Conconno	O.C.M.E.	Nov	ember 27, 2004
	30. Name and address of person what is a second of the sec	completed cause of death (Item 23a) (Type, 1111)	Penn Street, Bal	timore, Mar	yland 21201
State Registrar	DEC 0 2 200		B		

Amend State of Maryland & Berartment 95 Health and Mental Hygiene 1 - For State Registrar 38088 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month LANG /Medical 35 2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BUTNIE UNCLE GIEN TANIE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 21326 12 M 2□ F 9828 Director May 25, 1931 SAltimore Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner aust be notified at Director 1 ☐ Yes 2. No 10e. Street and Number BUTNIE 101. Zip Code 10g. Citizen of What Country? or Itams 23a or lenview 210 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No KCrCG If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ Specify: White 3 ☐ Widowed 4 ☐ Divorced naturel 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then any njury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) MANager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Noland -eslie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave, - Wife 618 GIENVIEW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Cremotor Battimore 21. Signature of Funeral 1 e Licensee 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit The law requires that the death certificate be executed 220 Records, P.O. Box 68760 Physician/Medical as attending p IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death Month Day Year 5 ☐ Other (specify) the 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performed? Division of Vital 1 Yes No No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30568 26.04 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLEN BULNIC MO ROD DU 784 5 OAK 2004 32. Registar's Signature 02 State Registrar

State of Maryland / Department of Health and Mental Hygiers 0 0 1 38089 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 28, 2004 **Physician** AUGUSTUS NEAL 3:24p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Min. Hours 1 □ M 2 🛱 F 213-26-4209 76 **Director** 7-10-1928 MARYLAND Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State 27 Is marked other than "netural", or Items 23e or 28e-f show treumatic event, the Medical Exartment is to restified at 1√2 Yes 2 □ No Director MD. ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 33 LINCOLN PARKWAY USA death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. e filed within 72 hours after cal Hygiene. I Hygiene. I other than "netural", or Iten 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by If Yes, Give Year or Dates: 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -0-SUPERVISOR ROAD MAINTENANCE MARYLAND STATE HIGHWAY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fi Health and Mental H tam 27 Is marked ot THERESA YOUNG SAMUEL NEAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 LINCOLN PARKWAY ANNAPOLIS, MARYLAND 21401 GAIL GREENLEAF (DAUGHTER) itam 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
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☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12-1-2004 OWENSVILLE, MARYLAND CHEWS UNITED METH. 4 ☐ Donation 5 ☐ Other (Specify) CHURCH 2 CHARLES OF Facility WH REESE & SONS MORTUARY P.A. 21. Signature of Funeral Service Licenses 821 WEST ST. ANNAPOLIS, MARYLAND 21401 Lavr 7 13, 15cese MOO 48 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical (or as a consequence of); Examiner sclende euo card Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
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[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 10 eted cause of death (Ite 23a) 32. Registrar's Signature State Registra

	ļ	State of Maryland / D	k Indelible Ink. Ensure All Cop Department of Health and Mental	Hygiene 0.0
Physici	an	Ragistrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death  2. Date Mon	of Death
/Medic	al	Francis A. Oechsler  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	28 2004 9:45 PM
Examin	er	FRANKLIN SQUARE HOSPITAL CENTER	ROSEDALE	BALTIMORE
Funeral Director		5. Social Security Number 6. Sex 1 3 2 F 7. Age (In yrs. last bin 9 2	thday) If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. Apr	of Birth nth, Day, Year) 1113,1912  9. Birthplace (State or Foreign Country) Maryland
rland ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	n or Location	10d. Inside City Limits
e Man te-fsh tiffsd	ctor	MD Baltimore Es	sex	1 ☐ Yes 2 No
with the or 28	<b>Funeral Director</b>	10e. Street and Number 8620 Kelso Drive	10f. Zip Code 21221	10g. Citizen of What Country? USA
death ms 23	nera	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	
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To the vithing To the comp	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		1 ASTON O	RES 6000	11-28-2004
<b>b</b>		30. Name and address of person who completed cause of death (Item 23a)  Dr. JOHN BROADNAX, 9000 FRAN  31. Date filled (Month, Day, Year)  32. Registrar's Signature	KLIN SQUARE DRIVE, BAY	TIMORE, MD 21237
Sta Regist		31. Date filed (Month, Day, Year) DEC 0 2 2004  32. Registrar's Signature	5 Spacks	

			For State Registrar	State of Maryland	Depa	rtment of Health tificate of Deatl	and M	ental Hygie		Ļ	38091
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last	Packs				2. Date of Death Month		ear	3. Time of Death  12-37A-M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location			4c. County of		
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<b>036</b> urs after de	ai', or itam Examiner o	by Fune	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	t	Vas Decedent of Hispanic C f Yes, specify Cuban, Mexic ☐ Yes 2☐ No Specif		cny Yes or No- Rican, etc.)	14. Race - Black, Specify:	White, et	
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arylan	marke matic	2	Elbert  19a. Informant's Name/Relationship (T)		19b. Mailir	g Address (Street and Num	ber or Rura		ta Parks ity or Town, Sta	ate, Zip C	ode)
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5 5	within 24 hours after usar To the Funaral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office	2	28f. Location (Stree City or Town, S		or Rural F	Route Number,
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17			30. Name and address of person who co	omprited ruse of death (Item 23		Print)				1	
*	Sta Registr		31. Date filed (Month, Day Year) 2 2	32. Registrar's Signature	15	Sports					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U 4 1 - For Stata Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Byrnina Baugher 30 Quinby November 2004 7:20A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral** Days 1 □ M 2X F Yrs. Director 217-20-7675 80 July 30,1924 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f shov 7 is marked other then "naturel", or Items 23e or 28e-f shov treumetic event, the Medical Examination ust be matthed at 1 Yes 2XXXII Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 704 Edmondson Avenue U.S.A. 21228 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 1 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 12 Bookkeeper Country Club 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be 1 Health and Mental Harry Baugher Grace Keating 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health Carole Harvey (Daughter) 6600 Overlook Court Sykesville, MD 21784 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial
Park Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Deportment o Importent: If any injury or once. ö 4 ☐ Donation 5 ☐ Other (Specify) 12-3-2004 Elkridge, Maryland 21. Signature of Funeral Service License Witzke Funeral Home of Catonsville, Inc 1630 Edmondson Avenue Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis

Due to (or as a consequence of): Pnysician /Medical cholecystitis Acute **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. CitrdiomyopAthy 1 Yes 2 No 3 Probably 4 Unknown Completed 0 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy LIJER 1 ☐ Yes 2 ☐ No VV hozes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 1 ☐ Yes 2 💢 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel I To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 30, 200x und

State Registrar

h

32. Registrar's Signature

6601 N. Charles Street

Baltimore, MD.

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kele

			1 - State AMENDTEM #	State of Maryland / December 26 PER VERB C838	Department of Health and ClarkWebb all Death	Mental Hygien	CULL	38093
	Physic	an	Decedent's Name (First, Middle, Last)		)	2. Date of Death Month D	ay Year	3. Time of Death
1	/Medi Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat	11-00111100	c. County of Death	51.01am
	Funeral Director		XXU 80-0601	7. Age (In yrs. last birt	thday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea /2-30-	9. Birth	place (State or Foreign mtry) ARYLANO
	Maryland If show	tor	Usual Residence of Decedent I  10a. State 10b. County  M. J.	10c. City, Town	or Location Daltimbre			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the	Director	10e. Street and Number 2701 E Fed	lexal Street	10f. Zip Code	10g. C	itizen of What Cou	intry?
36	hours after deeth with the Maryland tural', or items 23a or 28a-f show al Exeminer must be notified at	by Funeral	2.0	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1  Yes 2  10  Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White	
21215-0036	within 72 ene. then "nai	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a.	Decedent's Usual Occupation (Give kind of work done during most of working to NOT use retired)  1347454646	16b.	Kind of Business/Ir	ndustry RS V50NS
Maryland 2		To Be C	17. Father's Name (First, Middle, Last) AShley &	Reavis		ne (First, Middle, Maide	n Sumame)	
, Mar	s 1 and 2 should if Health and Mer tem 27 Is mark other traumatic		19a. Informant's Name/Relationship (Ty Ash Ley C. Rew?	196, Print) (Father) 196.	Mailing Address (Street and Number or Ru 701 E. Fedek	aral Route Number, City ALS+REG	+ 1	Code) 21213 D. Wd
Baltimore	0 0		20a. Method of Disposition  1 ☑ Burial 2 ☑ Cremation 3 ☐ R  `4 ☐ Donation 5 ☐ Other (Specify)		Disposition (Name of y, crematory or other place) 20 of Faith 11/	Date 20c. 1	ocation - City or T	own, State D. Md.
Ball	permit. Pag Department Important: I any injury o once.		21. Signature of Financial Service License	meles	22. Name and Address of Facility  Miller's Watte	politan C	hapel	P.C
	Physician /Medical		23a. Part 1. Enter the disease, of cornol shock, or hear failure. List only or Immediate Cause (Final disease or condition resulting in death)	Cardine	ot enter the mode of dying, such as cardiad  Arres +	or respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Unicerlying Cause (Disease or injury	Due to (or as a consequence of Due to (or a) (or as a consequence of Due to (or a) (or a) (or	n			yeurs
8760,	cate be executed oblysicien and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	d):			
.O. Box 68	ne death certifing the attending phed for use as	by Physician/Med	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	3c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 4  Pregnant at time of death 9  Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ery Day Year
<u>a</u>	ires that signed b	ed by Pr	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to t	š.,
al Records,		Completed				24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of
f Vital	ding Physicien: Th. h. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner?  1 Tes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Out	Othor	th (Check only one)	6 □Other (Specif	iv)
Division of	ding Afte fune		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Ti		28d. Describe how inju		,,
Divis	or A uffer Direction by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street a City or Town, State	nd Number or Rura e)	Il Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier (Check only one)  1 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one)	ician: To the best of my knowledge, her: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	and due to the cause(s rred at the time, date an	and manner as s d place, and due to	tated. the cause(s)
Y	To the To the Comp	M	29b. Signature and tifle of Certifier		29c. License number 0 00 5 4 3 3	6 29d. Da	ite signed (Month,	Day, Year)
	6		30. Name and address of person who co	mpleted cause of death (Item 23a) (	Type. Print) Colfe St Daltimore	MI 2:20	ີ າ	
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Sports!	11.0 00	) <i>!</i>	

3			For State Registrar	State of Ma	ryland / Depa <i>Ce</i> a	artment of I			giene Reg. No.200	4 38094
	Physici		1. Decedent's Name (First, Middle, Las	st)		Rose	1.265	2. Date of Dea	Day Yea	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of De	NO VERNORA	4c. County of D	eath
	Examin	er	11-2 Table 4	all oc 1	122 101	Mil	l'more		40. County of B	N/A
_			5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 h	Irs. 8. Date of Birt	th 9.1	Birthplace (State or Foreign
	Funeral Director			□м ¾□F	46 Yrs.	Months Days	Hours M	lin. (Month, Da May 31	y, Year)	Country) Virginia
			Usual Residence of Decedent		40			IVIAY 3 I	, 1936	Virginia
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar-f sl	ţō	Maryland N	/A		В	altimore			1X Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show salical Experiments be notified at	al	2412 Loyola Northway A	pt #104			21223		U.	S.A.
	ems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of I	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	- 14. Race - A Black, W	merican Indian, hite, etc.
98	or it		1 Never Married 2 Married	1 Yes 2 No		1 ☐ Yes 2 ☑ No			Specify:	Black
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						
5	d within 72 ho piene. ir than "natui ir e Medical	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of	working	16b. Kind of Busine	ss/Industry
12	within ene. than "	ם	Elementary/Secondary (0-12)	College (1-4or 5+	) ""6.		cretary		Department	of Social Service
2	e filed Il Hygie other		17. Father's Name (First, Middle, Last)				,	Name (First, Middle,	Maiden Sumame)	
ano	ed ital	Be	Jonnie Ra	wlings Sr					Marie Rawling	IS
Maryland	s 1 and 2 should by I Health and Menta item 27 la marked other traumatic e	2	19a. Informant's Name/Relationship (	<u> </u>	19h Maili	na Address (Street	and Number or		er, City or Town, State	
Ma	d 2 sho th and t7 lamu traumu		Paul Rawlings Son	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				, Maryland 21	•	, <i>p</i> 0000)
	is 1 and 2 of Health item 27 other tr		20a. Method of Disposition	·	20b. Place of Dispo	sition (Name of		Date	20c. Location - City	or Town, State
10	0 O		1 ☑ Burial 2 ☐ Cremation 3 ☐		1	natory or other pla		12/03/04		wn , Maryland
Baltimore,			* 4 □ Donation 5 □ Other (Specifical Service Liver	4		's Memorial F 2. Name and Addre		12/03/04	Randaisto	WII , Waiyialid
Ba	permit. Departr Importe any inju		21. Signature 1 times Solvice Land		-			neral Home P.	Α.	
			23a. Part1. Enter the disease or com	nlications that caused t	he death. Do not en	1300 E	utaw Place	neral Home P. Baltimore, MI	D 21217	Approximate
	8		shock, or heart failure List only Immediate Cause (Final	one cause on each line	1/	1		,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Iulmanak	y Hyrek	tension	)			9 months
н	Examiner			Due to (or as a	consequence of):					9 months.
		<u></u>	Sequentially list conditions,	b. Due to for as a	CONSCIUENCE ON.					Syenes
	ted nsit	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	,	, ,,,					
	be executed sician and burial-transit	хаг	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					-
8760,	siciar buri									
687	ficate to physical to the the the the the the the the the the	Physician/Medical		d						
Вох	eath certific attending p	M/C	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o					23d. Date of	delivery
ĕ	atte d for	cla	in the past 12 months?	1□Live birth 2 4□Pregnant at ti		∃Ectopic pregnand ∃ Other (s <i>pecify)</i> _	ту		Month	Day Year
O.	that the de ed by the a detached	ysi	9 Unknown	9□ Unknown						
٥	The law requires that the death certificate be executed to has been signed by the attending physician and labe 2 should be detached for use as the burial-transit		Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
rds	quires n sign ald be	d by	Obesity					101	res 2.⊒1√0 3□	Probably 4 Unknown
00	w require been s	Completed	Audiba ADREC	L				24a. Was	an 24b. Were	autopsy findings available
Re	The lav	щ	CHACINE III						rmed? death	
of Vital Records,		Ö	25. Was case referred to medical				26 Place of I	1☐ Yes Death (Check only o		es 2 No
⋚	ysician: is certific director,	o B	examiner?	Hospital: 1 Inpatien	t 2 ER/Outpatier	nt 3□ DOA Ot	hon		dence 6 □Other (S	nacifu)
	Phy ar this aral o	<del> </del>	27. Manner of Death	28a. Date of Injury (Month, Day			and the same of th		now injury occurred	pecnyy
O	rding Ph th. : After thi s funeral	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio		Year) Injury		rk? ]Yes 2 □No			
Division	or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b	286. Place of Injur	y - At home, farm, str	reet, factory, office			Street and Number or	Rural Route Number,
á	al or A after I Direct d in by	erti	4 Homicide	building, etc.	(Specify)			City or Tox	vn, State)	
	Hospita 24 hours Funeral tely filled		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge, deat	h occurred at the ti	me, date and pla	ace, and due to the	cause(s) and manner	as stated.
	B Fu	edical	(Check only 2 Medical Exert one)	niner: On the basis of e and manner state		vestigation, in my	opinion, death o	ccurred at the time,	date and place, and c	lue to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificicompletely filled in by the funeral director.	Me	29b. Signature and title of certifier	C .		29c. Licen	se number		29d. Date signed (Mo	
			4 Junes	Igolov	M.D.	RES-	000		VOVE mber	28 2004
	n		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,				November 1287	00,000
	0		Epilly Sydnor 6	00 N. Walfe	s Stoppet	BAH: MO	e. Mae	Wand 2	1287	
	Sta	itė	31. Date filed (Month, Day, Year)	32. Registrar			-	1	~_/	
	Regist	rar	QEC 022	nna Sen	wa G	lon	41			

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death
Physi	cian	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 2.1
/Med Exam Funera Directo	iner	Curtis Robinson, Sr.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Shan Hose itn  5. Social Security Number  6. Sex  1 M 2 F  88 Yrs.  4c. County of Death  N/A  4c. County of Death  N/A  4d. County of Death  N/A  4d. County of Death  N/A  4d. County of Death  N/A  4d. County of Death  N/A  4d. County of Death  N/A  4d. County of Death  N/A  5. Social Security Number  6. Sex  1 M 2 F  88 Yrs.  80 Age (In yrs. last birthday)  Months Days Hours Min.  Aug 30, 1916  Kentucky
the Maryland 28a-f show	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limit           Maryland         N/A         Baltimore         1 ☐ Yes 2 ☐ N
3a or 28s	Funeral Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?  U.S.A.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel", or items 23a or 28a-f show eny injury or other traumatic event, Ite W. dical Examination is statistical at	þ	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.)  14. Race - American Indian, Black, White, etc.  1 □ Yes 2 □ No Specify: Specify: Black
21215-0036 d within 72 hours att giene. er then "neturel", or	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Shipping  16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)  Shipping
Taryland 2121 2 should be filed within and Mental Hygiene. Is marked other then aumatic event, II w.M.	To Be Co	12 17. Father's Name (First, Middle, Last) Thomas Robinson  18. Mother's Name (First, Middle, Maiden Sumame) Mary Robinson
Maryland and 2 should be file alth and Mental Hy 27 Is marked oth or traumatic event,	-	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Sandra Robinson  19b. Mailing Address ( <i>Street and Number or Rural Route Number, City or Town, State, Zip Code</i> )  3915 Calloway Road Apt # 508 Baltimore, Maryland 21215
Baltimore, Moemit. Pages 1 and 2 Department of Health mportant: If item 27 I any injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition (Name of cemetary, crematory or other place)  King's Memorial Park  20c. Location - City or Town, State  12/04/04  Randallstown, Maryland
Baltimo permit. Page Department o Important: If eny injury or	i Silice	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217
60,  be executed  Wedicze Examine  ician and  burial-transit	I	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unlease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):
Box 687. death certificate e attending physical of for use as the	Physician/Medical	d
Records, P.O. The law requires that the e has been signed by the age 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1 Yes 2 No 3 Probably 4 Munknow
Rec he taw e has b age 2 st	Completed	24a. Was an autopsy findings availab prior to completion of cause of death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No
on of ding Phys h. After this funeral dis	ation: To Be	25. Was case referred to medical examiner?  1
는 Parit	Certification:	3 Suicide 6 Could not be determined 6 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
he Hospitel on 24 hours at he Funerel Epletely filled it	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To the h within 2. To the complet	M	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  PES - ØØØ  NOVEMBER 28: 20 CM
( 'b		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  J. A. YOHO MO ZYO! W. SEVYEDZIE ALE. BALTIMUE, MO ZIZIE
Regi	state strar	31. Date filed (Month, Day, Year)  32. Registrar's Signature  Aparta

ROBINSON, CHRIS

			for Stata Ragistrar		partment of Health and N Certificate of Death	fental Hygie	2004	38096
			1. Decedent's Name (First, Middle, La	st)		2. Date of Death		3. Time of Death
	Physici /Medio		Carl Ro	ay Koss, JR		11 2	Day Year 04.	8.17A. M
E.	Examir	ner	4a. Facility Name (If not institution, giv	re street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			5. Social Security Number 6. S	Sex 7. Age (In yrs. last birthd	av) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		MORE
	Funeral Director		232-108-98860	M 2 F 60 Yrs	Months Days Hours Min.	(Month, Day, Ye	ar), cou	place (State or Foreign ntry)
	ס		Usual Residence of Decedent			W 73 7	7·   W·	J
	arylar show	_	10a. State 10b. County	10c. City, Town o				10d. Inside City Limits 1 ☐ Yes 2 ZNo
	he M.	Director	10e, Street and Number	1 MORE	Timonium			
	with the same	ä	10 Quiet	Strang Ct	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	can Indian,
9	or Her		1 Never Married 2 Married	1 ☐ Yes 2 😿 No	12	Rican, etc.)	Black, White,	etc.
93	irat', c	d by	3 ☐ Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: ()	nite.
21215-0036	within 72 hours after death with the Maryland ane. then "naturat", or items 23s or 28e-f show he Medical Evaining the notified at	Completed by	15. Decedent's E (Specify only highest gro	ade completed) (G	ecedent's Usual Occupation live kind of work done during most of work e. DO NOT_use retired)	ing 16b	. Kind of Business/Ir	UCHON.
12	filed within Hygiene. Ither then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) ""	If En Olaund	(	Solf- En	dough
	illed Hygie other	Be Co	17. Father's Name (First, Mieddle, Last	) 1 0	18. Mother's Name	e (First, Middle, Maid	len Sumame)	progot.
<u>la</u> n	should be and Mental is marked o	To B	Carl Kay	Ross JR.	Ruxi	h Hinki	le.	O
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiane. If itam 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic avant. Its Medical Examinations is notified at	-	19a. Informant's Name/Rela in hip (	Туре, Print) 19b. М	ailing Addrass (Street and Number or Run	al Route Number, Cit	y or Town, State, Zij	Code) 21093
	1 and Health am 27 ther tr		Mark A. KOS	55 - 500 10	Quiet Stream Ct	., Apt.C	TIMON	ion MD
Baltimore,	Pages 1 nent of H int: If ital		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐		sposition (Name of Crematory or other place)	Date 20c.	Location - City or To	own, State
Ħ,	Fire Pa		' 4 ☐ Donation 5 ☐ Other (Special	EVANSFL	NERACHAPEL-11-3	004 50	rest Hil	1 ms
Bal	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Service Lice	2 1 P	22. Name and Address of Facility 32			TUM MOZIOZ
		-	23a, Part1, Enter the disease, or com	plications that caused the death. Do not			EALOCKE	MATION CIR
J			shock, or hear failure. Ust only Immediate Cause (Final		enter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Due to (or as a consequence of):	endianyopathi	1		years
8-	Examiner			Dimeres	mallitus	,		LITEOS.
	P =	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C				
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit			Due to (or as a consequence of):				
687	physicate sthe	dical		d.				
Box (	eath certific attending p	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	_		23d. Date of delive	erv
B.	death e atte d for	Physiclan/M	in the past 12 months?	4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
P.0	t the de by the tached	hys	9 🗆 Unknown	9□ Unknown				
	res tha igned be del	by F	Part II. Other significant conditions	contributing to death but not resulting in th	e underlying cause given in Part I.	N.4	o use contribute to the	
ord	w require been sign	ted				1 X Yes	2 No 3 Prot	pably 4 Unknown
Records,	has b	Completed				24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
alF						performed 1 ☐ Yes 2		2□ No
Vital	Physicien: this certificatal director,	o Be	25. Was case referred to medical examiner?	Hospital:	Othor	(Check only one)	14	
of	Phys r this eral di	-	1 ☐ Yes 2 ☑ No 27. Manner of Dat	28a. Date of Injury 28b. Time	e of 28c. Injury at	me 5 Residence 28d. Describe how in	-	Hospice
Division	Attending I r death. ector: After by the funer	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio		y Work? M 1 ☐ Yes 2 ☐ No		. ,	
N.	Attendi er death. ector: A by the fu	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rura	al Route Number,
Ö	tal or rs afte at Dir	Certification:					ŕ	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		(Crieck of a Medical Exal	filmar: On the basis of examination and/o	eath occurred at the time, date and place, r investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as s	tated.
	To the h within 24 To the F complete	Medical	29b. Signature, and title of certifier	and manner stated.	29c. License number			
	T W S		a /	Lan	DCR 202		Date signed (Month,  JCMOOL	
,	6		30 Name and address of parson who	completed cause of death (Item 23a) (Typ	De Print)		VEVIOUL	ayoug
	<u> </u>		A-ADROL - I DI	trains mo	6601 N. Charles Str	eet Balt	imore, MD	. 21204
:	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	& Sparks			

0817 ROSS, CARL

			1 10000		/ Department of Health and I	•	_	
			1 - For State Registrar		Certificate of Death	Reg.	211111	38097
-	Physici	an	Decedent's Name (First, Middle, Last	t)	Sawwar		Day Year	3. Time of Death
	/Medio	cal	Johnny 4a. Facility Name (If not institution, give	extract and number)	Sawyer		r 28, 2004	08:20 M
	Examir	ier	The Johns Hopk		Baltimore City	1	4c. County of Death	
	Funeral		5. Social Security Number / 6. S	7. Age (In yrs. lasi	birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthp	place (State or Foreign
	Director	(	DUCATUUT /	20 F 324	Yrs. Months Days Hours Min.	Month, Dayy Ye	30 MAZ	ZHANG
	and land		Usual Residence of Decedent  10a. State 10b. County	10c City, T	own or Location		1	0d. Inside City Limits
	the Marylar 28a-f show	tor	NO NA	13/4/	Limore			1. No 2 □ No
	or 28s	Jirec	10e. Street and Number	HPM ALIC	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	th w 238	Funeral Director	1914 N. CLV	WHI AVE.	2/202		1. S. H.	
	ter dea	-une	11. Marital Status  **TorNever Married 2☐ Married	12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Yo	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
036	ours aft	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 25 No Specify:		Specify: 5/14	CL
21215-0036	72 hours "naturel",	Completed by	15. Decedent's Ed (Specify only highest gra	ucation 1 de completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of work	king 16b	. Kind of Business/Ind	dustry
121	within ane. then	mpl	Elementary/Segondary (0-12)	College (1-4or 5+)	STEED WAS retired)	A	emio s	Itee/
	be filed tal Hygi d other event, I	Be Co	17, Father's Name (First, Middle, Last)	1 0	18. Mother's Nan	ne (Eirst, Middle, Majo	len Surpame)	
/lan	s should be fited within and Mental Hygiene. is marked other then sumatic event, It a M.	To B	GEORGE WAShUNGH	N SAWVEK	MACY	6. 40st	EK.	
Maryland	S is a		19a. Informant's Name/Relationship	pe. Printy P CAYON	19b. Mailing Address (Street and Number of Ru	ial Royte Number, Cit	PAN Staje, 49	OCE NO
	os 1 and 3 of Health item 27 other tr		20a. Method of Disposition	HUYEN STEA	e of Disposition (Name of	Date C 29c	-2/2	20 -
Baltimore,	0 = 5		1 Surial 2 ☐ Cremation 3 ☐	Removal from State	etery, crematory or other place)	204 AA	Location - City or To	wn, State
ij	permit. Pag Department Importent: any injury once.		21. Signay@re of Funeral Service Licen	1	22. Name and Address of Facility	BENH B	ANNIS JO	AINECAL
ä	Depa Impo any ir		I MATHICUY	Laumore	HOME 1362 N.CEN	HEAT AVE	BUATA	M. ZON
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. [	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	7-7-1-0	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Assiration p	neumonia		4	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequen				0 110 001 0
	-	ler	Sequentially list conditions, if any, Isauma to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequen	č€ ∪f).			
	cuted nd ransit	Examiner	that initiated events	C				
90,	ate be executed thysician and the burial-transit		resulting in death) Last	Due to (or as a consequen	ce of):			
8760,	cate b	dical		d				
Box 6	eath certific attending p for use as	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delive	0/
	death e atte	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death				Day Year
P.0	at the de by the stached	hys	9 □ Unknown	9□Unknown				
	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	by	Part II, Other significant conditions co				use contribute to th	
orc	w requir been si should	Completed	MID S (Megu	irea Immune	Deficiency Syndrom		2 XNo 3 □ Proba	ably 4 Unknown
Rec	0 - 0	mpl				24a. Was an autopsy performed?	prior to con	osy findings available inpletion of cause of
la	icien: Th certificate ector, pag	e Co	25. Was case referred to medical			1 Yes 2	lo 1 ☐ Yes	2 No
N N	Physicien: this certific ral director,	OB	eyaminer?	Hospital: 1 Nnpatient 2 ☐ ER/	Other	th (Check only one) ome 5 - Residence	6 Other (Specific	1
0	ding Ph h. After th funeral	T :uc	27. Manner of Death 1 Natural 5 ☐ Pending		b. Time of 28c. Injury at Mork?	28d. Describe how in		/
Siol	Attending r death. sctor: After by the funer	catic	2 ☐ Accident investigation		M 1 Yes 2 No			
Division of Vital Records,	or Atl	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specily)	, farm, street, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural ite)	Route Number,
	spitel ours a nerel (		29a. Certifier 1 Certifying Phy	sicien: To the best of my knowled	dge, death occurred at the time, date and place,	and due to the cause	(c) and manner as et-	atod
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exem	ner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occur	red at the time, date a	nd place, and due to	the cause(s)
	To ti To ti comp	M	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, L	Day, Year)
•	3		Nadeen Hose	in, Medical Doc	tar Res-000	Nov	ember 28	3, 2004
			30. Name and address of person who c	ompleted cause of death (Item 23	etar   Kes - 000 a) (Type, Print) Is Hospital, 600 North	1.110 (1	Baltin	nore,
	Sta	te	31. Date filed (Month, Day, Year)	e Johns Hopkin  82. Registrar's Signature	s Hospital, 600 North	Welfe Str	eet, Maryl	and 21287
	Registr		MTC A P 2004	k. A K	Angels )			

1			State of Marylan	d / Department of Certificate			ene20	04 3	8098
Physicia	ın	1. Decedent's Name (First, Middle, Lesi	Smith			2. Dete of Deeth Month	Dey	Year	me of Death
/Medica	al	4a Fecility Name (If not institution, give	Street end number)		4b. City, Town, o	NOVEMBER or Location of Death	22, 2 4c. County		2 P.M.
LXamine		Johns Hopkins Hosp	pital		Baltir			N/A	
Funeral Director		5. Social Security Number 6. Se 214-50 Add 1	× Age (In yrs.	Ast birthday) Yrs.  If Under 1 Y Months D	ear If Under 24 Hi ays Hours Mi		Yeer / 1	MACY/A	tate of Foreign
death with the Merylend rms 23s or 28s-1 show rmust be notified at	ctor	10a.,State 10b. County	BA	Town or Location				-	ide City Limits Yes 2 □ No
ith with the 23e or 28	Funeral Director	10e. Street and Number N. BE	the/St.	10f. Zip Co	13		g. Gitizen of l	What Country?	
Definition (e.) Wall yield ZIZIS-0020  Demit. Pages 1 and 2 should be filed within 72 hours after death with the Menyler  Depertment of Health and Mental Hygiene.  Important: If flem 27 is marked other than "natural", or flems 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at	<u>۾</u>	11. Marital Status  Discover Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 Myes 2 □ No 1f Yes, Give Year or Dates:	S. 13. Was Decedent If Yes, specify	of Hispanic Origin? Cuban, Mexican, Pue No Specify:	(Specify Yes or No- erto Rican, etc.)		e - American Indi ck, White Jetc.	an,
within 72 h ene. than "natu	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) Collège (1-4or 5+)	16a. Decedent's Usual O (Give kind of work of Jife, DO NOT use r	one during most of w	vorking 1	6b. Kind of Bi	usiness/Industry	
yidilid ZIZIS-OUZO ould be filed within 72 hours after Mental Hygiene. arked other than "natural", or ite artic event, the Medical Examina	To Be C	17. Father's Nerile (First, Middle, Last) TREASMICTA,	Be.		18. Mother's N.	ame (First, Middle, M	aiden Surnan	eds	
end 2 sho end 2 sho ealth end 1 m 27 is me		19a, Informant's Name/Relationship (T)	LK.	19b. Mailing Address (S	V. Beth	El St. K	WALLON,	Stafe, Zip Code)	013
permit. Pages 1 Depertment of H Important: If Ite any Injury or ott		20a. Method of Disposition  Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State	lace of Disposition (Name of programs of the p	FOREST	Date 2	Oc. Location	City or Jown/Sta	MOLEPA
Depentit. Depentit. Importe		21. Signal (tre of Funeral Service Light)	telmore	HOWE!	BOON, CE,	VACAPA	VE. E	AKO M	1, 2,202
Physician		23a. Pert1 Enter the diseese, or comp shock, or heart failure. List only o	ications that caused the deeth ne cause on each line.	n. Do not enter the mode of	dying, such as cardi	iac or respiratory arre	st,	Interva	ximate al Between and Death
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ATHEROSCU	EROTIL CA	ROIDVA	SCULAR	DISE	bE 34	
	ē	resulting in south	Due to (o	r as a consequence of):				1	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequence of).					
	Medicai	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence of):				1	
attend after us	cian					not Bidas			-1.1-11.0
w requires that the death certifications igned by the attending should be detached for use e	y Physician/M	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the underlying caus	e given in Part I.		s 2 No	ntribute to the ca	4 Unknown
The law requires that the death certiate has been signed by the attending paga 2 should be detached for use e	Completed by					24a. Was an perform	autopsy ed?	24b. Were auto available completio of deeth?	opsy findings prior to n of cause
The I						1 <b>X</b> Ye	s 2 No	1 <b>X</b> Yes	2□ No
sician certifi irector	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ DOA	Other:	eath (Check only one Home 5 Aesider		(Cassita)	
ding Phys	on: To	27. Menner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of 28c.	Injury at Work?	28d. Describe ho			
or Attendi	Certification:	Natural 5 ☐ Pending investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, of	1 Yes 2 No	28f. Location (Str. City or Town,		er or Rurel Route	Number,
	edicai Ce		sician: To the best of my knowner: On the basis of examinat and manner stated.						use(s)
To the within To the comple	Me	29b. Signature and title of continer	•		Cense number		_	d (Month, Dey, Ye	
7		30. Neme end eddress of person who co	wello, HD		L		_	1 04 004	
Stat	e	31. Dete filed (Month, Day, Year)	2. Registrar's Signa	111 Penn S	treet, Bal	rrimore, M	arylan	1 21201	
Registra		DEC 0 2 2004	Stown &	Species					

Registrar DHMH 16 Rev 6/95

			1- For State of Maryland / Department of Health and Mental Hygien 2004 3809	99
r		- 4	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of De	
	Physici /Media		Doris Smith November 26 2004 17:2	9 M
	Examir	ier	Johns Hopkins Bayview Medical Center  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death	
	. Funeral Director		5. Social Security Number 6. Sex 1 0 - 20 - 5747  Usual Residence of Decedent  7. Age (In yrs. last birthday) 1 1 M 2 1 F  9. Birthplace (State or For Country) Months Days Hours Min.  9. Birthplace (State or For Country) Months Days Hours Min.  9. Birthplace (State or For Country) MARYLAND	oreign
	yiand how		10a. State 10b. County 10c. City, Town or Location 10d. Inside City L	imits
	Be-f sl	ctor	MD BALTIMORE BALTIMORE 10 YOS 25	ZV0
	e or 2	Funeral Director	10e. Street and Number  10f. Zip Code 10g. Citizen of What Country?  21234  10g. Citizen of What Country?	
	death ms 23	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Bace - American Indian	
5-0036	within 72 hours after death with the Maryland ane. then "naturel", or items 23s or 28e-1 show 's Medical Exertine must be notified at	by	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, specify:  1 Never Married 2 Married 2 Married 1 Yes 2 No If Yes, Specify:  1 Yes 2 No Specify:  Specify: White, etc.	
15-0	"naturel",	letec	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working)  (Give kind of work done during most of working)	
2121	filed within Hygiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  Clerk  Clothing Store	
	be filed tal Hygid d other	BeC	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)	
Maryland	ihould be filed withir de Mental Hygiene. marked other then matic event, II.e.M.	<b>T</b>	Luiai Hloisi Louise Tulley	
Mai	a ie		19a. Informant's A-Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code)  Linda L. Woods-daug  346. Welleven Ro. Ainville FA 1730	7
Jre,	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City r Town, State	d.
<b>Baltimore</b>	Pages iment of tent: If it		14 Donation 5 Other (Specify) More and Mem. Park 12-1-04. Park VILLE ms	
Ball	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility BALTI more, mb 21234.	0
			23a. Part 1. Enter the dises or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between	
	Physician	1	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Cerebro Vo.5cular Accident  a. Cerebro Vo.5cular Accident	th
	/Medical Examiner		Due to (or as a consequence of):	
	- 1 J	ē	if any, leading to immediate  b. Spinal Cord Injury  Due to (or as a consequence of):	
	cuted Id ansit	Examine	cause. Enter Underlying Cause (Disease or injury	
30,	cate be executed physician and the burial-transit		that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  C.   WII   Due to (or as a consequence of):  C.   WII   Due to (or as a consequence of):	
38760,		dical	d. CLRIIFICATION APPROVED BY MEDICAL EXAMINED	
ox (	death certifi e attending id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery	
.O. B	0 0 0	Physician/Me	in the past 12 months?  1	
S, P	es that gned b	by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1?
ord	w requir been si should		1 Yes 2 No 3 Probably 4 donkn	nown
I Record	The lay ate has page 2	Completed	24a. Was an autopsy findings avail prior to completion of cause death?  1 Yes 2 No 1 Yes 2 No	lable e of
Vital	9 S S	o Be	25. Was case referred to medicat examinate 26. Place of Death (Check only one)  Hospital: Hospital: 1 Florations 2 FRO Other: 4 FRO Oth	
ō	g Phys er this eral di	-	27. Manner of Death  28a. Date of Injury  28b. Time of  28c. Injury at  28d. Describe how injury occurred	
Division	Attending I ir death. ector: After by the funer	ertification;	1 Natural 5 Pending 2 Describent investigation November 2 200 UNX M 1 Yes 2 No Fell down Stairs	
) i Vi	F 6 F C	ıtific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	Service of
_	spitel	O	29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	1234
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	edical	one)    Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To t To t	Σ	29b. Signature and titigent autiliar 29d. Date signed (Month, Day, Year)	
,	0,	1	T. BIVALA COMA RES 0 00 11/29/04	
_	\		Trinity Bivalacova 4940 Eastern Avenue, Baltimore, MD 21224	
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	
	negisti	ai	DEC 0 2 2004 Denne B Sporks	

38100 State of Maryland / Department of Health and Mental Hygiene () () |

			1 - State Registrar		C	ertificate of	Death	R	eg. No.	00100
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Deal Month	th Day Year	3. Time of Death
	Physici /Medic		Walt	er Smallets				November		11:30 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea	ath	4c. County of Death	
			Laurel Regional H			Laure			Prince G	
	Funeral		5. Social Security Number 6. S	ex 7. Age (li ⊠M 2□F	n yrs. last birth o 84 Yrs	Months Days	If Under 24 Hr Hours Mir	n. (Month, Day	Year) 9. Birth Cou	place (State or Foreign intry)
	Director		205-12-7680 Usual Residence of Decedent		04	,		pan. 14,	, 1920 Pellii	Sylvania
	land ow		10a. State 10b. County	10	Oc. City, Town o	r Location				10d. Inside City Limits
	Many -f sh	ō	MD Anne Aru	nde1	Lа	urel				1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	intry?
	death with the Maryland ms 23a or 28a-f show rmust be notified at		232 Old Line Aven	ue		2	0724		USA	
	deat	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Decedent of H	Hispanic Origin?	(Specify Yes or No-	14. Race - Amer Black, White	
٥	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or Itema 23a or 28a-1 show event, the Medical Examination not be notified at	F.	1 ☐ Never Married 2 💢 Marned	1 X Yes 2 ☐ No	1942- 1945	1 ☐ Yes 2 ☒ No		, , , , , , , , , , , , , , , , , , , ,		ite
1215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:					*****	
ភ	"natu	Completed	15. Decedent's Ed (Specify only highest gra	fucation de completed)	16a. D	ecedent's Usual Occu <sub>l</sub> Give kind of work done fe. DO NOT use retire	pation during most of w of)	rorking	16b. Kind of Business/li	ndustry
7	within 72 ene. than "na	E D	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		ccountant	<b>o</b> /		US Gove	rnment
7	Hygie ther int.		17. Father's Name (First, Middle, Last)			Coodingane	18. Mother's N	ame (First, Middle, i		
and	d be set of o	To Be	Simon Smallets				Eva Li	ıtskovets		
Mary	shoul nd Me mark	F	19a, Informant's Name/Relationship (	Type, Print)	19b. N	lailing Address (Street			, City or Town, State, Zi	p Code)
Ž	th ar		Clara Smallets/Wi	.fe	23	2 Old Line	Avenue	, Laurel,	MD 20724	
စ်	ges 1 and 2 should be filed wil t of Heatth and Mental Hygien If Itam 27 is marked other th or other traumatic event, Ita		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pla	ce)	Date	20c. Location - City or T	own, State
Ē	Pages nent of I ant: If Its ury or o		14 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif			1 Cemetery	1	4/2004	Laurel, MD	
Baitimore,	permit. Pages Department of I Importent: If Its any injury or o	- 1	21. Signature of Funeral Service Lifer	1	· •	-			Funeral Hom	e, P.A.
ñ	Ped F a g		Lauren	mach MO 016	0	313 Talbo	tt Avenu	ue, Laurel	L, MD 20707	
9	三口(引		23a. Pert : Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do not	enter the mode of dy	ng, such as cardi	ac or respiratory arr	est,	Approximate Interval Between
	Physician	i n	Immediate Cause (Final disease or condition	Pneumo	nia					Onset and Death Acute
	/Medical		resulting in death)	Due to (or as a c		:				
	Examiner		Conventinity list conditions	b					B. B.	
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of)					
11	nd	Examiner	that initiated events	c						
Š	e exe ian a urial-		resulting in death) Last	Due to (or as a co	onsequence or)					
09/89	ate b	Medical		d						
	death certificate be executed a stending physician and and for use as the burial-transit		IF FEMALE:	23c. If yes, outcome of p	oregnancy				22d Date of dain	
õ n	attend for us	Physiclan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 [ 4 Pregnant at tim	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		23d. Date of deliver Month	Day Year
o.	0 0	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	o or dought	o in other (opeany)				
1	requires that the de leen signed by the a hould be detached f	/ Ph	Part II. Other significant conditions of	ontributing to death but n	ot resulting in t	ne underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
dS	uires sign	d by	Congestive Hear	t Failure				1 🗆 Yı	es 2□No 3□Pro	babiy 4 ⊠Unknown
Ö		Completed	Coronary Artery	Disease				24a. Was a		opsy findings available
ě Y	The la	E C		DECORDO				autops	med? death?	ompletion of cause of
Vital Records,		0	25. Was case referred to medical				26. Place of D	eath (Check only on		ALAINO
5	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1X Inpatient	2 ER/Outp	atient 3 DOA Ot	her		ence 6 Other (Spec	ify)
וס נ	g Physie ter this oneral direction		27. Manner of Death	28a. Date of Injury (Month, Day Y	ear) 28b. Tin		ry at	28d. Describe ho	ow injury occurred	
<u>ö</u>	ath. or: Af	atic	1 Natural 5 Pending 2 Accident investigation	n			Yes 2 □ No			
Division	tal or Attending PI s after death. at Director: After the ed in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		<ul> <li>At home, farm Specify)</li> </ul>	, street, factory, office		28f. Location (SI City or Town	treet and Number or Rui n, State)	al Route Number,
	itat o irs aft rat Di led ir		N N							
	Hospital or Attending 24 hours after death. Funerat Director: After tely filled in by the fune	edical	(Check only 2 Medical Exam	nysicien: To the best of n niner: On the basis of ex	amination and/	death occurred at the to or investigation, in my	me, date and pla opinion, death oc	ce, and due to the co curred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the Hospital of within 24 hours after the Funeral D completely filled in	Med	29b. Signature and title of certifier	and manner stated	J	29c. Licen	se number	2	9d. Date signed (Month	. Dav. Year)
	Zo Zoi		In the American	1/10-						
			na a		b //b-= 00:1 00		1997		December	1, 2004
	16+1		30. Name and address of person who			rpe Print) le, Laurel,	WD 30.	707		
	Sta	ate	Luis A. Casas  31. Date filed (Month, Day, Year)	32. Registrar's		C, Dantel,	1.10 20	101		
	Regist		DEC 0.9 201	1.8	as hi	1				

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			Registrar				Cel	uncai	e or L	Jeau	I		Reg. I	No.			0.
	Physici	an	Decedent's Nam	e (First, Middle, L.		Manda	. Cab	0010				2. Date of D Month		Day	Year	3. Time o	
	/Media		4- Casilla Nama /	16 a l aia. ai		-	na Sch		Ŧ			Novem					5 A M
	Examir	ier			ve street and number	7		,	Town, or	Location	or Death			4c. County			
				Health (				Laur				<del></del>				eorge	
	Funeral		5. Social Security N		Sex 7. A 1 ☐ M 2 □ F	ge (In yrs. la	-	If Under Months		Hours Hours	Min.	8. Date of B (Month, D	irth ay, Yea	ar)	9. Birth	npiace (State untry)	or Foreign
	Director		051-40-	4000	10 M 2 X F	59	Yrs.					July 1	11,1	945		York	
	p .		Usual Residence o	1		10.00	-										
	ahow	_	10a. State	10b. County		10c. City	, Town or Lo	cation								10d. Inside C	•
	Ma	cto	MD	Prince	George	Lau	rel									1 ☐ Yes	2 <b>X</b> No
	h th	ē	10e. Street and Nu	mber				10f. Zip	Code				10g. (	Citizen of V	What Cou	untry?	
	38 G	0	14200 L	aurel Pa	rk Drive			207	707				ī	J.S.A			
	Jeat Jeat	era	11. Marital Status		12. Was Deceden		6.   13. 1			spanic O	rigin? (Sp	ecify Yes or N Rican, etc.)				ican Indian,	
10	a the	Ē	1 ☑ Never Man	ried 2 Married	Armed Forces					n, Mexica	ın, Puerto	Rican, etc.)		Blac	k, White	, etc.	
33	L's a	by Funeral Director	3 Widowed		If Yes, Give Year or Dates			1 🗌 Yes	2XXNo	Specify	<b>'</b> :			Specify	Whi	te	
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-1 ahow na Madigal Exh.cirler transl be toolified at	Completed		15. Decedent's E	ducation		16a. Dece	dent's Usua	al Occupa	ition			16b.	Kind of Bu			
15	in 7	ojet		cify only highest gi	rade completed)		(Give	kind of wo	rk done d	<i>urina</i> mo	st of work	ing				,	
12	filed within Hygiene. other then ent, the Men	E	Elementary/Seco	ondary (0-12)	College (1-4or	5+)	Secr	etary	7				Ch	urch			
	Hyg ther int,		17. Father's Name	(First, Middle, Las				ocar j		18. Moth	er's Nam	e (First, Middle			16)		
an	ould be f Mental I Mrked of	Be		Henry Scl								lindwoi			,		
3	2 should be filed withir and Mental Hygiene. In marked other than aumatic avent, the Ma	2															
Maryland	2 st and lan			ame/Relationship								al Route Numi	-				_
	and ealth m 27		Barbara		/sister							hesapea	<u> </u>				5
ore.	of H		20a. Method of Dis		☐Removal from State	20b. Pla	ace of Dispo	sition (Nari na <i>t</i> o <i>ry</i> or o	ne of ther place	e)		Date	20c.	Location -	City or T	own, State	
Ĕ	Pag nent int: h			5 Other (Spec			Arunde	el Cr	emat	ory	Nov 2	23, 04	Ode	enton	, Ma	ryland	1
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f ahov any injury or other traumatic event, the Modical Examiner must be notified at once.		21. Signature of Fy	uneral Service Lice	nseg		22	. Name an	d Addres	s of Facil	ity						
ä	Depar Impo		1 tehl	46	11/2	M00						Home, I aurel,		vland	3 20°	707-43	89
	- 100		23a. Part1. Enter 1	the disease, or cor	nplications that cause	d the death.								yzanc		Approxima	te
	8		shock, or hea	6	y one cause on each	line.										Interval Be Onset and	
	Physician /Medical		disease or condition resulting in death)	on	· · · · · · · · · · · · · · · · · · ·	oscler										years	
ħ.	Examiner				Due to (or a												
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ox 68760, ≤	n certificate be executed anding physician and use as the burial-transit	Examiner	that initiated events	S	c. Due to (or a	5 2 CODSOGUE	ance of:										
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87	hysi the t	n/Medical		•	d												
9)	ing pass	Mec	IF FEMALE:														
	th ce tendi		23b. Was deceden		23c. If yes, outcom 1☐Live birth		icy death 3	Ectopic pr	egnancy					23d. Date			
. B	death ne atte	sici	in the past 12	No ON	4☐Pregnant : 9☐ Unknown			Other (sp						Mor	ntn	Day	Year
P.0	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Physicia	9 Unknown														
	es tha igned be de	by P	Part II. Other signi	ficant conditions	contributing to death	but not resul	ting in the ur	nderlying c	ause give	n in Part	1.	23e. Did	tobacco	use contr	ribute to	the cause of	death?
of Vital Records,	w require been sig should b	be be	Periph	neral vas	cular dis	ease						1 🗆	Yes	2 🗌 No	3 🗆 Pro	bably 4 💢	Unknown
00	w re s bee	Completed										24a. Was	an	24b. V	Vere auto	opsy findings	available
Re	The lav	Ē										auto		р	rior to co leath?	ompletion of o	cause of
a												1 Yes	21	lo 1	☐ Yes	2 XN0	
ξ	Physician: this certific ral director,	Be	25. Was case reference examiner?		Hospital:				Othe	r.		(Check only					
ot	Phys this ral dii	2	1 ☐ Yes 2 ☐ 27. Manner of Deat		1 inpat		R/Outpatien			4 00 14		me 5 Res				(y)	
	al or Attending P after death. I Director: After t d in by the funera	Certification:	1 X Natural	5 Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time of Injury		8c. Injury Work			28d. Describe	now inj	ury occurr	ed		
sic	Attending ir death. ector: After by the fune	cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not i	ne l			М		'es 2 □							
Division	l or At after of Direct I in by	Tit.	4 Homicide	determined	286. Place of it	njury - At hor etc. <i>(Specify)</i>	ne, farm, str	et, factory	, office			28f. Location ( City or To	Street a	and Numbe te)	er or Rur	al Route Nun	nber,
	ital or ral D											Nagh day.					
	t hot une lune	cai	29a. Certifier (Check only	1 ② Certifying P 2 ☐ Medical Exa	hysician: To the bes miner: On the basis	t of my know of examination	rledge, death	occurred .	at the time	e, date a	nd place,	and due to the	cause(	s) and mai	nner as s	stated.	(2
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	one)		and manner s	tated.											,
	With To	2	29b. Signature and	title of certifier		4		290	. License							Day, Year)	
•			,	prita	m >1				D289	998			Nov	zembe:	r 23	, 2004	ŀ
	4		30. Name and addi	ress of person who	completed cause of	death (Item	23a) (Type,	Print)									
	1		Pritan	n Saini,	M.D. 910	l Cher	ry Lai	ne, S	te 2	11,	Laur	el, MD	207	708			
	Sta		31. Date filed (Mon	ith, Day, Year)	32, Regis	rar's Signatu						,					
	Registr	ar	NF	C 0 2 200	4 500	s-and	B	dom	Kal								

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year George Henry Schaeffer 15:18 PM Mou 29,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days 64 216.36.4341 Director June 10, 1940 Maryland Usual Residence of Decedent 10c. City. Town or Location 28a-f show 10d. Inside City Limits event. It's Mudical Exeminer must be notified at Director 1 Yes 2 No Maryland Howard Oella 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21043 751 Oella Avenue U.S.A. or Items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Caban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 25 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify White 3 Widowed 4 Divorced "natural", Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Building other then Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Carpenter 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill treent of Health and Mental H tant: If Item 27 Is marked out Allen Schaeffer Helen Schindell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 Is any injury or other trau 751 Oella Avenue Ellicott City, Maryland 21043 Ms. Clair Schaeffer Spouse Baltimore, 20a. Method of Disposition

1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) 12/04/2004 Ellicott City, Maryland Good Shepherd Cemetery 21. Someture of Funeral Service Lie 22. Name and Address of Facility Slack Funeral Home, P.A MOD535 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Ischemia **Physician** hours /Medical Due to (or as a consequence of): **Examiner** Atherosclerotic Cardiovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physiclan/Medical Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 ☐ Probably 4 ☐Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 No 1 Yes 1 Yes 2 🗀 Nố 25. Was case referred to medical examiper? completely filled in by the funeral director, 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 FroOutpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attending 1 Matural Injury 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier (Check only one) 296. Signature and title of certifier 29d. Date signed (Month, Day, Year) Deput NE 1,20041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO ATTW 0 TOYE MO ZIOL

DHMH 17 Rev 1/2001

State Registrar

31. Date file TMOnth 02. Years) 4

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

		1 - For State Registrar	State of Maryla		artment of			iene 0 0	4 38103
		Decedent's Name (First, Middle, Last	)				2. Date of Dea Month	th	3. Time of Death
Physi /Med	ician dical	ELIZABETH G.	STORCK		,		NOVEMBE	IR 30 2	2004 5=40 AM
Exam		4a. Fecifity Name (If not institution, give	///		4b. City Town,	or Location of	Death	4c. County o	
		5. Social Security Number 6. Se	sing Hom	rs. last birthday)	If Under 1 Year	If Under 2	4 Hrs. 8 Date of Birth		imore  9 Birtholeca (State or Foreign
Funera Directo				3 Yrs.	Months Days		Min. 8. Date of Birth (Month, Day 8-23-1	931	Birthplece (State or Foreign Country)     MD
ס		Usual Residence of Decedent							
arylan show	_	10a. State 10b. County  MD Baltimo		City, Town or Lo					10d. Inside City Limits 1 Yes 2 No
Ne Me	ecto	10e. Street and Number	ore	Roseda	10f. Zip Code			log. Citizen of Wh	nat Country?
with the or	Funeral Director	1812 Greencastle I	rive		212	37		USA	,
death ms 23	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13.			in? (Specify Yes or No- Puerto Rican, etc.)		- American Indian, White, etc.
Dalfill Ofe, INITY INITY INITY 2 NO. 2000  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene.  Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, Ita Medical Examinat must be notified at	b	1 Never Married 2 Married	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No		Fuelto Floan, etc.)	I	White
72 ho	ompleted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retin	upation e during most o	of working	16b. Kind of Bus	iness/Industry
ithin and	n ple	Elementary/Secondary (0-12)	College (1-4or 5+)	1	DO NOT use retir maker	ed)		Own Hom	20
iled w tygiel thert	O	12 17. Father's Name (First, Middle, Last)	0			18. Mother	's Name (First, Middle,		-
VIGITIC build be file Mental Hy arked oth attic even	To Be	John E. Howard				Mar	ry Heiser		
Maryla d 2 should th and Men t7 is marke traumatic		19a. Informant's Name/Relationship (7					or Rural Route Numbe		itate, Zip Code)
1 and 1 Health tem 27		Mary Antkowiak/Dau					Shrewsbury :		1 City or Town, State
Pages 1		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from State	_	osition (Name of matory or other pl of Faith		12/3/2004		
DESILTIMON Permit. Pages Department of mportant: If it iny injury or or		* 4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Ligen:	<u>_</u>		2. Name and Add		his	Rosedal	neral Home
De de de de de de de de de de de de de de	Sign	100		- 33	1211 Che	saco Av	e Baltimor		237
類		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the done cause on each line.			_		est,	Approximate Interval Between Onset and Death
that the death certificate be executed EXECT THE WAY BY STATE OF THE PROPERTY	ical Examiner		U. The state of th	sequence of):	Fan	lun	e.		
the death certifical true attending phyche attending phyched for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3[	□Ectopic pregnan □ Other (specify)			23d. Date Mont	of delivery h Day Year
	ğ	Course of Do	ontributing to death but not	resulting in the u	inderlying cause g	given in Part I.		bacco use contrit es 2 □ No 3	oute to the cause of death?
	Completed	Authribs					24a. Was a		ere autopsy findings available
	om p				,1		autop perfor 1  Yes	med? de	ior to completion of cause of path?  Yes 2 \sum No
VITAI iician: T certifical rector, p	Be C	25. Was case referred to medical				26. Place	of Death (Check only or		
Of VITAL Physician: r this certifica	10 E	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2		nt 3L DOA		sing Home 5 Resid		
ing P	on:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer	28b. Time of Injury	W	uryat ork? ⊒Yes 2.⊟N		ow injury occurre	d
DIVISION  Tor Attending after death.  Director: After in by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not be		it home, farm, st			281. Location (S	treet and Number	r or Rural Route Number,
DIO A affer Direct Direct din by	Certification:	4 Homicide determined	building, etc. (Spe	ecify)	,,,		City or Tow	n, State)	
DIVISION  To the Hospitel or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deal	th occurred at the nvestigation, in my	time, date and opinion, death	place, and due to the con occurred at the time, o	ause(s) and man late and place, ar	ner as stated. nd due to the cause(s)
To the Within To the compl	Me	29b. Signature and title of certifier	17			nse number	1		(Month, Day, Year)
		) Griffih	Gran, InD		Dec	5985	55 /	lovemi	bu 30, 2004
Λ	7	30. Name and address of person who	completed cause of death (	Item 23a) (Type.	Print)	100	10 8	113	21239
	State	31. Date tiled (Month, Day, Year)	32. Registrar's Si	gnature CO	1 Klive	MI DI	10, Das	MURE	41259
	State istrar	BFC 0.2.2004		1 Son	K)				

			1 - State Amend Items	State of Maryland 1,26 per Dr., G	d / Department of Healt <b>838<sub>6</sub>12//02/04/hb</b> ea	h and Mer ath	ntal Hygier	2001.	38104
	Physic /Medi		1. Decedent's Name (First, Middle, Last  Juanit:		JUANTH	Δ_		Day Year 25 2004	3. Time of Death
	Examir		4a. Facility Name (If not institution, give	ircle.	4b. City, Town, or Locati	on of Death		4c. County of Deat BaH	more
	Funeral Director			M 200 F 7	Yrs. Months Days Hou	irs Min.	Date of Birth (Month, Day, Yea ) - 12 -	33	hplace (State or Foreign untry)
	death with the Maryland ms 23a or 28a-f show Finual to notified at	ctor	10a. State 10b. County  Battu	more 10c. City	r, Town or Location RandalS	town			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with th	ral Director	9548 Wesland (	lide	10f. Zip Code	3	10g. (	Citizen of What Co	untry?
980	ours after ral', or Ita Examina	by Funeral	11. Marital Status  1 Newer Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 IV No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex		Yes or No- an, etc.)	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	be filed within 72 hours after ital Hygiene. od other than "natural", or Italian avent, The Medical Examina	Completed	15. Decedent's Ed. (Specify only highest grad	cation (e completed) College (1-4015+)	16a. Decedent's Usual Occupation (Give kind of work done during r life. DO NOT use retired)	most of working	16b.	Kind of Business	lor Vehicle
yland ;	e d fa	To Be C	17. Father's Name (First, Middle, Last) Harry L. Junes	Sr.	N	Partha	irst, Middle, Maide Leach	en Sumame)	
	1 and Health tam 27		19a. Informath's Name/Relationship (7)  Denuse Multiple (1)  20a. Method of Disposition	aves Daughter	19b. Mailing Address (Street and Nun 4215 NOVFOLK A ace of Disposition (Name of	-	Sattimo	000	21210
Baltimore,	permit, Pages Department of Important: If it any injury or c		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	Kerioval from State	metery, crematory or other place)  Memorial Park  22. Name and Address of Fa	12-4-	04 Br	etemore,	Maryland exal sixes.
200	Physician /Medical Examiner		23a. Part1. Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line.  a. PANCREAT Due to (or as a consequence)	C CANCER	THE ROLL OF THE	Spiratory arrest,	300M, []	Approximate Interval Between Onset and Death
38760,	icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Du					
O. Box 6	ne death certif the attending thed for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 ☐ Ectopic pregnancy			23d. Date of deli	very Day Year
Δ.	w requires that the bod by should be detact		Part II. Other significant conditions cor	ntributing to death but not resu	lting in the underlying cause given in Pa	art I.	23e. Did tobacco	_	the cause of death?
al Records,	. « •	Completed					24a. Was an autopsy performed?	prior to death?	opsy findings available ompletion of cause of
Vital	sician; Th certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital: 1 ☐ Inpatient →	Other	ace of Death (Ch			
sion of	Attanding Physician: r death. actor: After this certific by the funeral director,		27. Manner of Death  1 XNatural 5 Pending 2 Accident Investigation	1	28b. Time of Injury M 1 Yes 2	28d.	Describe how inju	6 □Other (Spec ury occurred	ify)
Division	To tha Hospital or Attand within 24 hours after death To tha Funeral Diractor: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify)			City or Town, Sta	,	
	To tha Hosp within 24 hou To tha Fune completely fi	Medical	29a. Certifier (Check only one)  12 Certifying Physical Examination Check only one)	sician: To the best of my know ner: On the basis of examination and manner stated.	rledge, death occurred at the time, date on and/or investigation, in my opinion, o	and place, and death occurred at	due to the cause( t the time, date ar	s) and manner as and place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		29c. License numbe			ate signed (Month,	
			12/0-		D0067		NOW	ember :	26,2004
			30. Name and address of person who con 401 NORTH (31. Date filed (Month, Day, Year)	mpleted cause of death (Item  ROADWAY  32. Registrar's Signatu	BALTIMORI	F, MA	RYLAN	1) 21	231
	Sta Registr		<b>DEG 0 2</b> 2004	Berse &	Sporks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registres Certificate of Death Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death **Physician** Yeer 4:23 PM /Medical JOVEMBER 2004 Examiner m, or Location of Death 4c. County of Death Age (n yrs. last birthday) **Funeral** 1 □ M 2 □ F Months Days Director the Maryland State items 23a or 28a-f show 10d. Inside City Limits Completed by Funeral Director TOYES 2 No with 10g. Citizen of What Country? death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 O Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White/etc. Never Married 2 Married 21215-0036 ò 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
, fife. DO NOT use retired). 16b. Kind of Business/Industry Elementary/Secondary (0-13) other than ege (4-4or 5+) or other traumatic event, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked othe any injury or other traumatic event, 9068. 17, Father's Name (First, Midgle, Last) Be ner's Name /First, Middle Baltimore, 20a. Method of Disposition 20b. Pla 1 Burial 2 ☐ Cremation 3 Removal from State ' 4 □Dopation 5 □ Other (Specify) ture of Funeral Service License 21. Signa Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician Onset and Death MULTISYSTEM ORGAN FAILURE SECONDARY /Medical WUSEKS Due to (or as a consequence of): CHRONIC SEPSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury PERFORATED PRE-PILORIC GIASTRIC 4 mosks Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician need for use as the burial P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) Month Day detached 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown peen page 2 s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy performed' 1 ☐ Yes 2 No funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Certification: To 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/3 No 1 Inpatient After this 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Division 28d. Describe how injury occurred Natural 5 Pending death. investigation within 24 hours after death To the Funeral Director: filled in by the 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 36665 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACOB M. WISBECK MO EAST UMIVERSITY PARKWAY BALTIMURE MD ZIZIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 2 2004

DHMH 17 Rev 1/2001

MR # 00153382

		ľ	1 - For State Registrar		Maryland / Dep		of Hea	alth and i	Re	g. No.2 1 1	L 38106
	Physici	an	Decedent's Name (First, Midd						2. Date of Death Month	Day Ye	
	/Medic	al	BEVERLY  4a. Facility Name (If not institution	TROUTMAN	har)	4h City T	own orlo	ocation of Death		4c. County of D	
	Examin	er	SACRED HEAD			_		LAND		ALLEG	
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. last birthda)	) If Under 1	Year If	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		236-76-1105	1□M 2\\ F	69 Yrs.	WOTTERS	Days	HOUIS WIII.	Feb. 16		Vest Virginia
	and w		Usual Residence of Decedent  10a. State 10b. Count	у	10c. City, Town or I	ocation					10d. Inside City Limits
	Maryl -f sho	ţō	WV Min	era1	New	Creek					1 ☐ Yes 2 🔀 No
	r 28e	irec	10e. Street and Number		Tiew.	10f. Zip (			10	g. Citizen of What	Country?
	th with 23e o	al D	HC 72, Box 7	2-A			267	743		US	A
	ems	ıner	11. Marital Status	Armed Ford	ent Ever in U.S. 13	Was Decede	ent of Hispa fy Cuban, I	anic Origin? (S) Mexican, Puert	pecify Yes or No- p Rican, etc.)		merican Indian,
36	s afte	by Funeral Director	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 🕅 Divorce	If Yos Give	! <u>⊠</u> No	1□Yes 2				Specify:	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other then "naturel", or items 23e or 28e-f show or other treumatic event, the Medical Francial must be notified at	edt	15. Decede	nt's Education	16a. Dec	edent's Usual	Occupatio	าก	1	6b. Kind of Busine	White ss/Industry
215	nin 72 na "na Medili	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed)	(Giv	e kind of work DO NOT use	( done duri e retired)	ing most of wor	king		,
21	giene giene er the	Com	12			hlebot				Hospita	al Lab
nd	be filed tal Hygid of other event, I	Be	17. Father's Name (First, Middle				18	3. Mother's Nan	ne (First, Middle, M	aiden Sumame)	
<u>\</u>	should be filed within nd Mental Hygiene. s marked other then umatic event, in Me	2	Lester Zim				(2)		ace Peck	a	
Maryland	d 2 sho		19a. Informant's Name/Relation Sharron Sibley						ral Route Number,		e, Zip Code)
	of Health of Health if item 27 i		20a. Method of Disposition	Daugnter	20b. Place of Disc	t. 3,	e of	152 K10	deley, W	V 26753 0c. Location - City	or Town, State
Baltimore	Pages nent of I ant: If ite		1 ☐ Burial 2 MCremation 4 ☐ Donation 5 ☐ Other (					1	ov. 27	200	
altir	# E E E		21. Signature of Funeral Service		The Cumb	erland 2. Name and		of Facility	2004	Cumberla	1/3/
ä	Deparent Deparent Important in any ir		+ House	No Lout		85	S. Ma		Smith Fun eet Keys		e 26726
	Pnysician /Medical Examiner	-	23a. Part1. Enter the disease, of shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any Leading to immediate.	aDue to (o	r as a consequence of):	e b/a	of dying, s	31eed	or respiratory arres	st,	Approximate Interval Between Onset and Death 2 NOUTS
68760, W	ate be executed hysician and the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	r as a consequence of):						
387	phys phys s the			d							
P.O. Box (	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 ☐ Live bir	nt at time of death 5	□Ectopic pre □ Other <i>(spe</i>				23d. Date of Month	delivery Day Year
Records, P	w requires that been signed b should be deta	by	Part II. Other significant condit	tions contributing to dea	th but not resulting in the	underlying ca	use given i	n Part I.	23e. Did toba	1	e to the cause of death?  Probably 4 □Unknown
000	aw requ is been 2 shouk	plet							24a. Was an autopsy		autopsy findings available to completion of cause of
R	The late happened	Completed							perform		?
ita	slen: artifica ctor.	Be (	25. Was case referred to medic examiner?					6. Place of Dea	th (Check only one		
of Vital	Physiclen: r this certificatel director.	2	1 ☐ Yes 2 No		patient 2 ER/Outpatie		or white the contract of		ome 5 🗆 Residen		pecify)
n o	ling P	ion:	27. Manner of Death  Natural 5 ☐ Pend	mig .	Injury 28b. Time Injury		c. Injury at Work?		28d. Describe hov	v injury occurred	
Division	Attending or death. ector: After by the fune	licat	3 ☐ Suicide 6 ☐ Could	tigation and the last place of	f Injury - At home, farm, s	M treet factory		2 □ No	28f. Location /Stre	et and Number or	Rural Route Number,
Div	after Dire	ertii	4  Homicide	mined 286. Place of building	g, etc. (Specify)	,,	311100		City or Town,		
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier (Check only one)	ing Physician: To the bas il Examiner: On the bas and manne	pest of my knowledge, dea sis of examination and/or i or stated.	th occurred a nvestigation, i	t the time, in my opini	date and place on, death occu	, and due to the cau rred at the time, dat	use(s) and manner te and place, and c	as stated. due to the cause(s)
	To th Withir	Me	29b. Signature and title of certific	George f	fennawi, M		License nu	1HT9		d. Date signed (Mo	
	'5		30. Name and address of perso	n who completed cause	of death (Item 23a) (Type						
			George Hen	nawi(11)	925 3	ishop	wa	154 Re	1, Lumb	erland,	MD71502
	Sta Registi	-	31. Date filed (Month, Day, Yea	L.	gistrar's Signature	Spo					
DH	MH 17 Rev 1/2		DEC 0 2	2004 / 54	yere o	100	eks!				

ORIGINAL

			1- State Amend Item 8 State (Registrar	ntiMagybyndi.2Den: Cei	and propage Health and Martificate of Death		ne 2004 (	38107
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  MARGARET L. TOOG	OOD		2. Date of Death Month NOVEM	BER 28, 200	Time of Death
	Examir		4a. Facility Name (If not institution, give street and not 807 CARROLLTON AVE	ımber)	4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUND	EL
	Funeral Director		5. Social Security Number 6. Sex 220-24-56 18 Usual Residence of Decedent	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth3- (Month, Day, Ye 3-8-192	8-1928. Birthplace Country) MD.	(State or Foreign
	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or items 23a or 28e-f show ont, the Medical Evan if we must be indiffied at	Director	10a. State 10b. County MD ANNE ARUNDEL	10c. City, Town or Lo	S			Inside City Limits 1 ☐ Yes 2 ☐ No
	or death with the Marylar tems 23a or 28e-f show at must be mulfied at	Funeral Dire	10e. Street and Number  807 CARROLLTON  11. Marital Status 12. Was Dec		10f. Zip Code  21401  Was Decedent of Hispanic Origin? (Sp	Ţ	Citizen of What Country?  USA  14. Race - American I	
9036	ours after dea rel', or items	by	Armed F	orces?	f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.  Specify: BLACK	
Maryland 21215-0036	within 72 hours at iene. than "neturel", or	Completed	15. Decedent's Education (Specify only highest grade completed, Elementary/Secondary (0-12)  6 — College	(Give life. I	dent's Usual Occupation kind of work done during most of work DO NOT use retired) ODIAN	ing	. Kind of Business/Industr	гу
land 2	e d al	To Be Co	17. Father's Name (First, Middle, Last)  JAMES T. HAWKIN		18. Mother's Nam	e (First, Middle, Maid ET L. JOI		
	and 2 sh ealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print) DIANE FORRESTER	807 C	ng Address (Street and Number or Rur ARROLLTON AVE. AN	NAPOLIS	MD 21401	
Baltimore,	Page nent o ant: if ury or		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from  4 □ Donation 5 □ Other (Specify)	mt CALVAR	Y CHURCH 12-3	3-2004 AF		State
Bal	Departr Departr Imports any inju			1100483	Name and Address of Facility REF	APOLS, MD	21401	
	Physician /Medical		resulting in death)	cach line.	er the mode of dying, such as cardiac	or respiratory arrest,	Inte On:	proximate erval Between set and Death
	Examiner	nlner	Sequentially list conditions, "any leading to minorable cause. Enter Underlying Cause (Disease or injury	(or as a consequence of).				
8760,	cate be executed physician and the burial-transit	dical Examiner	that initiated events	(or as a consequence of):				
.O. Box 68	ne death certifi the attending thed for use as	Physician/Med	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day	Year
۵	The law requires that that the has been signed by page 2 should be detact	by	Part II. Other significant conditions contributing to d				co use contribute to the ca	use of death?
Vital Records,		Completed				24a. Was an autopsy performed'		tion of cause of
of	hys his I dii	atlon; To Be	27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatien of Injury th, Day Year)  28b. Time of Injury	t 3 DOA Other: 4 Nursing Ho	me 5 Residence 28d. Describe how in	6 □Other (Specify)	
=	tei or Attending P rs after death. ei Director: After t ed in by the funera	Certification;	3 Suicide 6 Could not be determined 28e. Place	e of Injury - At home, farm, streing, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Rotate)	ite Number,
	To the Hospitei or At within 24 hours after or To the Funerei Direct completely filled in by	edical	one) 2   Medical Examiner: On the E	e best of my knowledge, death asis of examination and/or inv ner stated.	occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as stated and place, and due to the	cause(s)
ı	0	Σ	29b. Signature and Hite of certifier		29c. License number		Date signed (Month, Day,	Year)
	5		30. Name and address of person who completed cau		ANNAPOLI	s mo		
	Sta Registr	6		Registrar's Signature	South !			

	, ,		for State Registrar	State of Maryland		artment of H			/	38108
	Physic		1. Decedent's Name (First, Middle, Last,			Thomas	2	2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	NOVEMBEL	4c. County of Deat	4.03 P M
			The Johns Hop	Kins Hospita	1	BAH	MORE		/	ULA
	Funeral Director		5. Social Security Number 6. Security Number 1 S	7. Agé (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) APRIL 15	= 1/2/1/3 1 a .	hplace (State or Foreign untry)  RYLAND
	ryland how		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	hours after death with the Maryland turel, or items 23e or 28e-f show at Exardres rough be notified at	Director	MARYLAND N	1A		SALT	IMORE	CIT	y	1 ✓ Yes 2 ☐ No
	with the		10e. Stréet and Number	2 / 2007		10f. Zip Code	0 00	_ 1/0g	g. Citizen of What Cou	untry?
	ter death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. )	Vas Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No-	14. Race - Amer	A rican Indian.
36	or ite	y Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	1	Yes, specify Cuba □ Yes 2⊠ No		Rican, etc.)	Black, White	, etc.
ö	72 hours "neturel", dical Ex	ed by	3 ☐ Widowed 4 💆 Divorced  15. Decedent's Edu	Year or Dates:		ent's Usual Occupa		1.40	Specify: BZ	LACK
21215-0036	be filed within 72 ho ital Hygiene id other then "netur event, In Medical	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of NOT use retired	furing most of working	16	6b. Kind of Business/I	ndustry
	e filed wi Il Hygien other th		10 THGRADE			NURS				IG HOME
Maryland	ld be fi ental h ked ot c eve	To Be	TO HALALI	$N_{\alpha}$	ww		18. Mother's Name		_	05.000
ary	ges 1 and 2 should be it of Health and Mental If item 27 is marked or or other treumetic ev	F	19a. Informant's Name/Relati Inship (Ty)				JOSEP and Number or Rural		City or Town, State, Zi	RESTER
-	and 2 ealth a m 27 t		CAROLINE WOODK	7 7 7	73	3 MELL	100 March 1997		ORE HD	
Baltimore	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ R	emoval from State Ce	metery, cren	sition (Name of patory or other place	9) ;			
altin			<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>	MT	· Z10	Name and Address	ERILIA -09	1-04 1	ANSDOWN	VE. MARKAND CAL HOME
ä	permit. Departr Importe any inji		Wietrich,	N. William	00	OSEPI 140 N	s of facility BR	TVB. SI	~ ' '	21217
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death.	. Do not ente					Approximate Interval Between
	Prysician /Medical		Immediate Cause (Final disease or condition resulting in death)	METASTATIC	Lu	16 CAN	024			Smooths Month
F	Examiner			Due to (or as a conseque	ence of):	35				
	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ence of					
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	anno of					
8760,	cate be executed physician and the burial-transit	dicai E	d	520 10 (01 23 2 551135406	once ory.					
68	rtificati ng phy as the	Aedic	IE ECMAIC.							
Вох	eath certifi attending for use as	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal of	death 3 🗍	Ectopic pregnancy			23d. Date of delive	
o.	at the de by the a stached f	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of dea 9☐ Unknown	ath 5	Other (specify)			Month	Day Year
o, D	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by PI	Part II. Other significant conditions con-	ributing to death but not result	ting in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribute to the	he cause of death?
Records,	w require been sig should b	ted						1 ☐ Yes	2 □ No 3 □ Prob	bably 4 Honknown
3ec	has b	Completed						24a. Was an autopsy	prior to co	ppsy findings available impletion of cause of
		0	25. Was case referred to medical				OO Diese of Death	performed		2 <del>□</del> No
	S 0 10	To B	examiner? 1 ☐ Yes 2 ☐ No Ho	ospital: 1 Inpatient 2 El	R/Outpatient	3□ DOA Other	26. Place of Death   4 □ Nursing Home		e 6 ☐Other (Specifi	iv)
Division of	ding Phi h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 28	d. Describe how i		,
/isi	l or Attending after death. Director: After in by the fune	ficat	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom	ne, farm, stre		es 2 🗌 No	f. Location (Stree	t and Number or Rura	al Route Mumber
	n ir	Certification:	4  Homicide determined	building, etc. (Specity)	-, ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, S.	tate)	rriodia ramber,
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	To th To th comp	ž	29b. Signature and title of certifier	<u> </u>		29c. License			Date signed (Month,	
	1		> Munder M			KES	.000	De	ECEMBER	,01.2004
	.7		30. Name and address of person who con	Johns Horkin	(Type, P	rint)	INFO ST RA	Himmer M	January 217	201.2004 287
	Sta		31. Date filed (Month, Day, Year)	d .	re P	UTI UVVVIU	INC VILLY	THERE, IN	114-41-11V4. X/J	0 /
	Registra	ar i	DEC 0 2 2004	interes 15	Board	وع				

Physicia /Medic Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show eny injury or other traumatic event. The Medical Example Incitied at ODGE.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
-	10. State of Maryland / Department of Health and Mental Hygiefe

Decedent's Name	e (First, Midd	Ile, Last) Alfre	d Lerov k	Villia	rtificate of l			2. Date of D				3. Time of Dea
		-Alfred	Leroy	Wi	lliams	Jr.		Month Novem		<sup>ay</sup> 29 <b>,</b>	2004	0054
. Facility Name (li	f not institution	on, give street and n	umber)		4b. City, Town, or	Location (	of Death		44	c. County	of Death	
		ere Hospit			Rosedal		2111			Balti		
Social Security N 16-56-9		6. Sex 1 <b>⊈</b> M 2 ☐ F	7. Age (In yrs. Ia 53	ist birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	3. Date of B (Month, D Jan 10	irth la <i>y, Year</i>	51	9. Birthp Cour Mary	olace (State or Fo
sual Residence of						1						
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e. Street and Nur		CIMOLE			10f. Zip Code				10a. C	itizen of \	What Cour	
3523 Da		Lane				220			_	SA		
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3 X Widowed		d Year or	Dates:	16a. Dece	dent's Usual Occup	ation			16b.		usiness/Inc	
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		nship (Type, Print)		19b. Maili	ing Address (Street						State, Zip	Code)
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Registrar DHMH 17 Rev 1/2001

State

Dr. Wachsman

Baltimore. Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

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should Ind Men	2	19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ng Addres	ss (Street	and Number or Ri		er, City or	Town, State,	Zip Code)
and 2 sealth ar n 27 is		Shelley LeBrun-	Daughter		3017	Wood	dspri	ng Dr.,	Abingd	lon,	MD 210	09
D		20a. Method of Disposition		20b. P	lace of Dispo emetery, crea				Date		cation - City or	
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ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	death 3		pregnancy	1		2	3d. Date of de Month	Day Year
the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time or a	eath 5L	Other (	sрөспу) <sub>—</sub>					
law requires that the as been signed by the 2 should be detached.		Part II. Other significant conditions	contributing to death b	out not res	ulting in the u	inderlying	cause giv	ren in Part I.	23e. Did	tobacco us	se contribute t	o the cause of death?
w requires to been signs should be	d by	101 - 101 100	POPI						1 🗆	Yes 2	2No 3□P	robably 4 Unknown
requence should	ete		Doctal	1 1	Failure	20			24a. Wa	s an	24b. Were a	utopsy findings available
10 8 8 CI	Completed		JY EIVER C	/_	MILLIA	<del>l</del>			auto	opsy ormed?	prior to death?	completion of cause of
n: Tr licate r, pa		OF Management to modical						an Plan of Do	1 ☐ Yes ath (Check only	2 No	1 L Yes	s 2 <del>110</del>
OI VILAI DE Physician: The Prints certificate he ral director, page	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	ont 2	ER/Outpaties	nt 3 🗆 [	Ott	00	Home 5 Res		S □Other (Sne	acify)
	: To	27. Manner of Death	28a. Date of Inju	ury	28b. Time o		28c. Inju	y at	28d. Describe			
VISION Attending ar death. ector: Atte by the fune	tio	1. ■ Natural 5 ■ Pending 2 ■ Accident investigation	(Month, Da	ay rear)	Injury	М	Wo	rk? Yes 2 □No				
Attending r death. ector: After by the fune	ifica	3 Suicide 6 Could not be determined	288. Place of in	jury - At ho	ome, farm, st	reet, facto	ory, office	<del></del>	28f. Location	(Street and	d Number or R	ural Route Number,
a after	Certification:	4   Hornicae	building, e	ic. (Specin	y)				Only or 1	, Glato,		
To the Hospital or Attending Phywithin 24 hours atter death. To the Funeral Director: After the completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  Certifying P  Certifying P	hysicien: To the best miner: On the basis of and manner st	of examina	wledge, deat tion and/or in	th occurre	d at the ti	me, date and place opinion, death occ	e, and due to the urred at the time	e cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)
To the within 2 To the complet	Mec	29b. Signature and title of certifier	and mained 3			2	9c. Licens	se number		29d. Date	e signed (Mon	th, Day, Year)
7 × 7 8		> ///m/1	V			and the second	D	41922	2	1	1/191	2004
	,	30. Name and address of person who	Completed cause of	death (Iten	n 23a) (Type	Print)	1		/ ^		1' !/	7
5		So. Harris address of person with	THISMAN	4	07 4	ritt	Minis	on fall th	we deg	MACI	1/10 2	1078
S	tate	31. Date filed (Month, Day, Year)	nna 32. Regist	rar's Siona	uure 19	1	man .	y's	· · · · · · ·	4	V	
Regis			TUO	*	1	19	per or tope	- 25.5				

				1- State of Maryland / Registrer	Department of Health and M Certificate of Death	lental Hygien	
		Physici		1. Decedent's Name (First, Middle, Last)		2. Date of Death	ay Year 3. Time of Death
		/Medic Examir		4a. Fecility Name (If not institution, give street and number)  Harford Merrorial Haspi		race.	c. County of Death Harfard
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last by 1 M 2 1 F 89  Usual Residence of Decedent	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year 9-23-1	S NORTH Carolina
		ne Marylan 8e-f show	Director	MD Harford	Forest Hill	140.00	10d. Inside City Limits 1 ☐ Yes 2 No
		72 hours after death with the Maryland Instural', or items 23e or 28e-f show Ocal Examilier rust be notified at	Funeral Dire	10e. Street and Number  2408 Minnick DR.  11. Marital Status  12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto		Ottizen of What Country?
	920	ours after d ral', or Iten Examiner	þ	Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puérto 1 ☐ Yes 2 █ No Specify:	Rican, etc.)	Black, White, etc.  Specify: White
	1215-0	within 72 ho no. then "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ing 16b.	Kind of Business/Industry
	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Model Examinet must be notified at 2008.	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	on Surname)
	, Mary	and 2 shou laith and M 27 is mar er treumat	-	ARIEHA W. Goetz 3	9b. Mailing Address (Street and Number or Rura 3055 GRAFTAN'S L	al Route Number, City  N. CHURA	or Town, State, Zip Code) 31028
	Baltimore,	Pages 1 ament of He ent; If item ury or oth		1 Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify)	ery, crematory or other place) SFUNELAL CHAFFL 1-3	8-04 FO	rest Hill, MD
	Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	LEVAUS FUNGERAL OF	HAPPI 12	DR., FOREST HILL DELAIR. MDJUST Approximate
		Physician /Medical		23a. Part1. Enter the disease or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)			Interval Between Onset and Death
300		Examiner	her	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ract infection		
- 1	, y	ate be executed obysician and the burial-transit	I Examiner	Cause (Disease of injury that initiated events resulting in death) Last  C. Due to (or as a consequence	us VICEVS		
שלו	x 68760	certificate b ding physic se as the b	/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
0	.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Unknown	th 3 Ectopic pregnancy 5 Other (specify)		Month Day Year
	ırds, P	equires that en signed t		Part II. Other significant conditions contributing to death but not resulting  Chymic obstwhve pulmme	in the underlying cause given in Part I.		use contribute to the cause of death?
Sladys	Vital Records,	The law reate has be page 2 sho	Completed by	thermatoid arthritis		24a. Was an autopsy performed? 1 ☐ Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
16		siclen: certific lirector,	Be	25. Was case referred to medical examiner? 1   Yes 2   To   Hospital: 1   Inpatient 2   ER/C	26. Place of Death Outpatient 3 DOA Other: Nursing Hor	n <i>(Check only one)</i> me 5 ☐ Residence	6 □Other (Specify)
0	n of	ng Phy ter this neral d	on; To		Time of linjury at Work?	28d. Describe how inju	
Vest	Division	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	M 1 □ Yes 2 □ No farm, street, factory, office	28f. Location (Street a City or Town, Sta	und Number or Rural Route Number, te)
Ke	_	Hospitel 4 hours Funerel ely filled		29a. Certifier (Check only   Medical Exeminer: On the basis of examination a	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	and due to the cause(sed at the time, date ar	s) and manner as stated.  nd place, and due to the cause(s)
		To the within 2 To the complet	Medical	29b. Signature and title of certifier	29c. License number	29d) D.	ate signed (Month, Day, Year)
	•	Ń		30 Name and address of person who completed cause of death (Item 23a	(Tyge, Print)	Vo	rember 48, 2004
		1/		D2 STANLEU KWH 1388 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Busiers Ct wy #	102 Ed	gevood 21040
		Sta Rogist		DEC 0.2 2004	D sporker		t .

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Zon4 GINIA 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (A not institution, give, street and number) Anne 6 Birthplace (State or Country) Social Security Number ge (In yrs. last birthday) 1 □ M 2 E Ĩ920 84 MD 219-50-6984 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h Count 10a State 1 ☐ Yes 2 TXNo Anne Arundel Linthicum 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21090 U.S.A. 419 Applegate Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify Specify: white 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George W. Cooper Virginia Lee Whistler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Ellen Leckner / daughter 609 Shipley Road, Linthicum, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial Park 2004 Sykesville, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Familial Service Libense 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Day Year

**Physician** /Medical Examiner

1-

**Physician** 

/Medical

Examiner

Funeral Director

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Completed

Be

**Funeral** 

Director

If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Madical Examined must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat; or Items 23s any injury or other traumatic event, the Medical Experience or ust any injury or other traumatic event, the Medical Experience or ust.

Baltimore, Maryland 21215-003

with the Maryland

Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi nding physician and nours after death.

neral Director: Af
filled in by the fur

Division of Vital Records, P.O. Box 68760,

dicai Examin	cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of): d	
by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 D No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year
Completed by Ph	Concestive No	contributing to death but not resulting in the underlying cause given in Part I.  HEATURE CHRONE ROULL  SYMMOME	23e. Did tobacco use contribute to the cause of death?  1  Yes 2  O 3  Probably 4  Unknown  24a. Was an autopsy performed? 1 Yes 2  No  1  Yes 2  No
Be	25. Was case referred to medical examiner?	26. Place of Death (	
2	1 ☐ Yes 2 No	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home	e 5 Residence 6 Other (Specify)
tification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	n (Month, Øay Year) Injury Work? 1 ☐ Yes 2 ☐ No	3d. Describe how injury occurred
tifle	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Cert

Medical

29a. Certifier

one)

30. Name and address of p

29b. Signature

31. Date filed (Month, Day, Year) DEC 0 2 2004

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

within 24 hours a To the Funeral L

the

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			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment rtificate			ind M		giene 0	04	38113
	Physici /Medic		Decedent's Name (First, Middle, Last)     HAROLD ROBERT WHIT	TE						2. Date of De. Month NoVEMB	ath Day /	2004	3. Time of Death
	Examir			PITAL		4b. City, T GLENK	BURN	IE	f Death		4c. Coun	ty of Death	NDEL
	Funeral Director				(In yrs. last birthday)	If Under 1 Months	Days Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da 7 / 4 / 19	th y, Year) 22	9. Birthr Cour KENT	place (State or Foreign ntry) UCKY
	Maryland f show	or	Usual Residence of Decedent           10a. State         10b. County           MD         ANNE ARUNI	)FT	10c. City, Town or Lo							1	IOd. Inside City Limits
	with the Page or 28e-	I Direct	10e. Street and Number 1203 WHITMAN DRIVE		GLEN DOKN	10f. Zip 0					10g. Citizen of	f What Cour	ntry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hyglene. If item 27 is marked other than "netural", or items 23a or 28e-f show if item 27 is marked other than "netural", or items 23a or 28e-f show or other traumatic event, the Medical Exactive frontified at	by Funeral Director		2. Was Decedent E Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:	0		ent of His fy Cubar	spanic Orig , Mexican, Specify:	in? (Spe Puerto l	cify Yes or No Rican, etc.)	- 14. Ra Bla	ace · Americ ack, White, ify: WHI	etc.
21215-0036	d within 72 ho giene. Ir than "netu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 54	(Give	dent's Usual kind of work DO NOT use DRIVE	done di retired)	tion uring most	of workir	ng	16b. Kind of I		•
Maryland	2 should be filed withir and Mental Hygiene. ia marked othar than aumatic event, Ine Mi	To Be C	17. Father's Name (First, Middle, Last) ROBERT LEE WHITE							(First, Middle, ONG GAI	Maiden Suma		
	and 2 sh salth and n 27 ia m		19a. Informant's Name/Relationship (Type RITA WHITE - WIFE	e, Print)	1203	WHITMA	AN DI				er, City or Town		Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is eny injury or other trau once.		20a. Method of Disposition  1   Buriaf 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	moval from State	20b. Place of Dispo cemetery, crea GLEN HAV	natory or oth	e of ner place			/2004	GLEN B	•	
Balt	permit. Departimport import eny inj		21. Signature in Funeral Sarvice Livense	- moni							FUNERA BURNI		
	Physician /Medical Examiner	_	234 Pay1. Enter the disease, or complic shock, or heart failure. List only one limitediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as a	the death. Do not ent.	er the mode	of dying	, such as c	ardiac o	respiratory ar	rest,		Approximate Interval Between Onset and Death
8760, 5	cate be executed oblysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any leading to this additions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. b. cause (Disease or injury that initiated events cause).		consequence of):								
.O. Box 6	The taw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic preg Other (spec						ate of delive	ory Day Year
rds, F	quires tha in signed uld be det		Part II. Other significant conditions cont	ributing to death but	not resulting in the u	nderlying cau	use giver	n in Part I.		23e. Did to			e cause of death? ably 4 □Unknown
al Reco	: The law requir cate has been si , page 2 should	Completed by	Ischemic	Can	rdio nu	100	a.t.	Ly		24a. Was a autop perfor	med?	Were autopprior to condeath?	osy findings available npletion of cause of
ion of Vital	utending Physician: The death. ctor: Atter this certificate h. y the funeral director, page	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 Inpatien 28a. Date of Injury (Month, Day			Other c. Injury : Work?	4 □ Nurs	sing Hom		ne) ence 6 □Oti ow injury occur		)
Division	tai or Atte s after det ai Diracto ad in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory,	office		2	8f. Location (S City or Tow	treet and Num n, State)	ber or Rura	l Route Number,
	To tha Hospital or Attending Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Medical (	29a. Certifier 1 ☐ Certifying Physic (Check only one) 1 ☐ Certifying Physic 2 ☐ Medical Examination	cian: To the best of er: On the basis of e and manner state	examination and/or in	n occurred at vestigation, in	the time	, date and nion, death	place, a	nd due to the o	ause(s) and m late and place,	anner as sta	ated. the cause(s)
)	To t To t	₩.	29b. Signature and title of certifier	ile	MD	29c.	License	redmun	35	- 2	29d. Date signe	od (Month, L	Day, Year)
	ĵD		30. Name and address of person who con New the Arund	pleted cause of dea	ath (Item 23a) (Type,	Print)	He	spit	0	Drive	Gle	n Bi	raje MM
	Sta Registr	- 20	31. Date filed (Month, DEC 0 2 2	32. Registra	Signature	3	Con	and a	4				

			1 - For State Registrar	State of	Marylar				lealth a		ental Hy	Reg. No2	004	38 1 4
	Physici	an	Decedent's Name (First, Middle, I RICHARD L		7.2	REMBA					Month	Day 29	Year 2004	. 10.15 PM
	/Medic	al	4a. Fecility Name (If not institution, g			ALUE ILACI	4b. City,	Town, or	r Location	of Death			ounty of Deet	h
	Examir	er	3000 MAYBERRY	RD			WES	STMI	NSTER				'ARROLL	
	Funeral			Sex 7	. Age (In yrs. 59		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De	rth ay, Year)		hplece (State or Foreign untry)
	Director		218-40-4310 Usual Residence of Decedent	ZUW ZUF	39	Yrs.		L			12–1-	-1944		MD
	land w		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Mary a-fab	tor	MD Baltin	nore		Roseda	le							1 ☐ Yes 2 🛣 No
	th the	Jirec	10e. Street and Number				10f. Zip					10g. Citize	n of What Co	untry?
	death with the Maryland rms 23a or 28a-f show	rai	1502 Rosewick A			0 1.0		1237		1.0.0			SA . Race - Ame	deep Indian
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heath and Mental Hygiene. ortant: if item 27 is marked other than "naturel", or items 23a or 28a-f show injury or other traumatic event, the Medical Extrations out be notified at as.	by Funeral Director	Narital Status     Never Married 2  Married     Microscope     Married 4 □ Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? No		Was Dece If Yes, spe 1  Yes	city Cuba	ispanic Ori in, Mexicar Specify:	n, Puerto	cify Yes or No Rican, etc.)	-	Black, White pecify: Whi	e, etc.
21215-0036	2 hou	ted	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usua	al Occup	ation during mos	at of workii	na	18b. Kind	of Business/	Industry
21	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT u	se retired	1)		.3	Brev	ioru	
121	filed with Hygiene other thai		12 17. Father's Name (First, Middle, La	0			Brew	ery	Worke		(First, Middle			
anc	d be fundal h	o Be	John S. Zaremba	31)							. Char		,	
Maryland	2 should and Men is marks	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street			l Route Numb		Town, State, 2	Zip Code)
	1 and 2 Health a om 27 is		Sandra Zaremba/	Sister-in			Mayb		Rd	A A A	minste		<b>2115</b> 8	
ore	of He of He if item or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3	☐Removal from S		Place of Dispo	matory or c	other plac			ate		tion - City or	
ij	Pages tment of tant: If it		* 4 ☐ Donation 5 ☐ Other (Spe	cify)	Ga	rdens (	_				-2004		edale	
Baltimore,	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Servica Lic				1211	Ches		ve ]	Roseda.	le MD		Approximate
68760,	Physician and /Medical Examiner the prival-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last	b	or as a consecutor as a consec	juence of):	OMA							Onset and Death
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	eg pe	by	Part II. Dther significant condition	S contributing to dea		sulting in the u	nderlying o	cause give	en in Part I	1.		tobacco use Yes 2		the cause of death?
000	aw requir s been s	Completed	PNEUMONIA								24a. Was		24b. Were au	topsy findings available
R		mo:	RECTAL CA	NCER							perfe	ormed? 2 X No	death?	
/ita	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?	11 2-1				0.4			(Check only			
of \	Physician: r this certific ral director,	L.	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ In 28a. Date of	patient 2	ER/Outpatier 28b. Time o	-				ne 5 Resi			cify)
no	ling After fune	tion	1 Natural 5 ☐ Pending	(Month	Day Year)	Injury	м	28c. Injun Worl	k? Yes 2□					
Division of Vital Records,	of or Attending after death. I Director: After din by the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of	of Injury - At h g, etc. (Speci	ome, farm, st fy)	reet, factor	y, office		2		(Street and I wn, State)	Number or Ru	ral Route Number,
	To the Hospitel or Attervible 24 hours after de To the Funeral Directo completely filled in by the	ledical C		Physician: To the tax caminer: On the bar and manner	sis of examina									
	To the To the Comp	2	29b. Signature and title of certifier	mg/		/			e number	pm		1	signed (Month	n. Day. Year)
,	3		36-9)		70106157	/		.ر	-515	22		12/01/	2014	
	1		30. Name and address of person with SGIN ANG, 916	no completed cause 3 FRANKLI	of death (Ite	n 23a) (Type, AFG D£	Print)	SUITE	- 220	0, B	ALTIMO	RE M	212	37
	Sta Regist		31. Date filed (Month, Day, Year) DEC 0 2 20											,

			For Stete Registrar		State of M	aryland .	Depa <i>Cei</i>	artment of H <i>tificate of l</i>	eaith and N Death	nental Hy	giene Reg. No	2004	38115
			1. Decedent's Name	(First, Middle, Las	st)					2. Date of Dea	ath		3. Time of Death
ı	Physici /Medio		Frank Thoma	s Abell						Month NOVEMBE	R J	y Year 18 2004	3:52 P M
	Examin		4a. Facility Name (If	not institution, give	street and number,	1		4b. City, Town, or	Location of Death		4c.	County of Deat	
			St. Mary's	Hospital				Leonardt				t. Mary's	3
	Funeral Director		5. Social Security Nu 578-12-2518		C C	ge (In yrs. last 7	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da January			hplace (State or Foreign buntry) 1and
	pu 🛊 🕠		Usual Residence of I	Decedent 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	sho	ō						Cation					1 ☐ Yes 2 ☑ No
	the N	Director	Maryland  10e. Street and Num	St. Mary's	8	Leonar	dtown	10f. Zip Code			10~ Cit	izen of What Co	••
	with Se or		22287 Cedar					20650			-		ournery r
	ns 2%	Funeral	11. Marital Status	Derece	12. Was Decedent	Ever in U.S.	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-		USA 14. Race - Ame	rican fndian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23e or 28e-1 show any injury or other treumatic event, the Medical Exactions to the notified at once.	δ	1 ☐ Never Marrie	**	Armed Forces' 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		į.	f Yes, specify Cuba I□Yes 2፟፟ No		Rican, etc.)		Black, White Specify: Whi	
20	72 ho	Completed		15. Decedent's Ed fy only highest gra		1	6a. Deced	lent's Usual Occupa	ation	ina	16b. K	ind of Business/	Industry
2	ithin 199.	npie	Elementary/Secon		College (1-4or	5+)	life. I	OO NOT use retired	)	mg			
2	ygier ygier her th		12				lechan	ic				S. Govern	ment
and	be fi	Be	17. Father's Name (F	, ,					18. Mother's Nam	e (First, Middle,	Maiden	Sumame)	
7	hould d Mei marke matic	ို	Thomas Hogan		Type (Print)		Ob Mailie	a Address (Street	Violet Chi		- City	Town Ctata 7	Zin Cordol
Ma	d 2 s th an t7 is i							g Address (Street a					up Code)
ē,	Heal Heal tem 2		Theresa Ann 20a. Method of Dispo		;	20b. Place	of Dispo	Cedar Stree sition (Name of	2	Cown, Mary Date		20650 ecation - City or	Town, State
Baltimore,	Pages ent of nt: If i			Cremation 3 5 Other (Specify	Removal from State			natory or other place orial Garde		2,2004 L	eona	rdtown, M	aryland
alti	permit. Departm Importe any inju		21. Signature of Fun				22	. Name and Addres	s of Facility				
<u> </u>	99 = 8		Muchas	Previn	Harden	1	T.	attingley-G	Marvland	20650		A., P. O.	Box 270
			23a. Part1. Enter the shock, or heart	e disease, or comp failure. List only	dications that cause one cause on each I	d the death. [	o not ente	er the mode of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Pnysician		Immediate Cause (F disease or condition	Final	a ASP	irahi	on	Syndro	me				Onset and Death
В	/Medical Examiner		resulting in death)		Due to (dr as	a consequen	ce of):						
		<u></u>	Sequentially list con-	ditions,	b. Die trificas	ito nia	na office						
	nted Insit	Examiner	cause. Enter Underl Cause (Disease or in	lying njury	Bou	rel	Av	nav tom	osil (	ehis	cen	æ	
Ć	execun nand ial-tra	Exal	that initiated events resulting in death) La	ast	Due to (or as	a consequen	ce of):						
68760,	tificate be executed g physicien and as the burial-transit	edicai			.d	lon (	Carc	er					
	ng ph as th		fF FEMALE:					17.7%					
P.O. Box	The law requires that the death certate has been signed by the attendin bage 2 should be detached for use	Physician/N	23b. Was decedent in the past 12 n 1 Yes 2 Unknown	nonths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3□	Ectopic pregnancy Other (specify)				23d. Date of deli Month	very Day Year
	w requires that been signed t should be det	ρ	Part II. Other signific	cant conditions co	ontributing to death t	out not resultin	g in the ur	iderlying cause give	n in Part I.			se contribute to	the cause of death?
Il Records,		Completed								24a. Was a autop perfor	sy med?	death?	topsy findings available completion of cause of 2 \sum No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referre examiner?		Hospital:			Othe	26. Place of Deat				
	Phys r this ral di	<u>۲</u>	1 Yes 2 N	10	1 Inpati 28a. Date of Inju		Outpatien b. Time of	28c. Injury	4   Nursing Ho	me 5 🗌 Resid 28d. Describe h			cify)
on	ding I	tion	1 Natural 2 Accident	5 Pending investigation	(Month, Da	y Year)	Injury	Work		200. 2000/100 **	ow man	y coodings	
Division of	i or Attending after death. Director: Aftel In by the fune	ifica	3 🗌 Suicide	6 Could not be determined	28e. Place of In	jury - At home	, farm, stre	eet, factory, office					ral Route Number,
5	s afte	Certification:	4 Homicide		building, e	tc. (Specify)				City or Tow	n, State,	)	
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only 2 one)	Certifying Ph	ysicien: To the best liner: On the basis of and manner st	f examination	dge, death and/or inv	occurred at the tim estigation, in my op	e, date and place, inion, death occurr	and due to the cred at the time, c	ause(s) late and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and	neo of certifier				29c. License	number	2	9d. Dat	e signed (Month	n, Day, Year)
				yu	1	ny		115	3007		1-	19-	04
		ĺ	30. Name and addre	SS of person who									/
	* Sta			7.	20 93	P J.BE ar's Signature	AN M	EDICAL CE	NTER HOI	LYWOOD,	MD.	20636	
	Registr	- 3	31. Date filed (Month	10V 22 2	004	med yo	2						

FRANK ABELL OK a) is post shire

			1 - For State Registrar	State of Ma	arylan		artmen rtificate			nd Me		jiene 10g. Nö.	004	38116
			Decedent's Name (First, Middle, L.	ast)						2	2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		George H	Emmanuel	Awk	ward				N			7, 2004	9:14 A M
	Examir		4a. Facility Name (If not institution, gi	ve street and number)			4b. City,	Town, or	Location of	Death		4c.	County of Dea	th
			1402 Anglesea S	Street Apt.	2A		Ва	1tim	ore C					
	Funeral. Director		5. Social Security Number 6. 213-46-7295	Sex 7. Age 1∭ M 2□F	58 (In yrs. 1	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day Nov. 1	Year)		thplace (State or Foreign buntry) Yland
	р ,		Usual Residence of Decedent  10a, State 10b, County		10- 03	. T			-					
	aryla ehov	<u>_</u>	10a. State 10b. County			, Town or Lo								10d. Inside City Limits 1 Yes 2 □ No
	Ba-f	Scto	MD		I	Baltim								
	or 2	Dir	10e. Street and Number				10f. Zip				1	log. Citi	zen of What Co	ountry?
	ath v	ral	1402 Anglesea S					2122					ted Sta	
	er de	nne	11. Marital Status	12. Was Decedent I Anned Forces?			Was Deced If Yes, spec	lent of Hi rify Cuba	spanic Origi n, Mexican,	in? (Speci Puerto Ri	ify Yes or No- ican, etc.)		<ol> <li>14. Race - Ame Black, Whit</li> </ol>	
36	s aft	γF	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ N	lo 19∈ 19∈	- '	1 ☐ Yes 2	≥ <b>X</b> No	Specify:				Specify: D	l 1-
9	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f ehow he Madical Everifing must be motified at	pg p	15. Decedent's 8	Year or Dates:	19		dent's Usua	d Occup	ation			16h Ki	. D and of Business	Lack
15	n 72	lete	(Specify only highest g	ade completed)		(Give	kind of wor DO NOT us	rk done d e retired	luring most ( )	of working	7	TOD. KI	IIU UI DUSINOSS	modstry
21215-0036	withi Bne.	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or 5 2	+)		abled		,			Dis	abled	
	filed Hygi Sthar		17. Father's Name (First, Middle, Las	<del></del>		D # D.	abica		18. Mother	's Name (	First, Middle,			
an	d be ental ked c	To Be	James Walker						The	odor	is Nola	an		
Maryland	should be filed within and Mental Hygiene. s marked othar then "umatic event, the Men	1	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a					r Town, State, 2	Zip Code)
M	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparment of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importents: If item 27 is marked other then "neturel; or Items 23e or 28e-f ehow any injury or other treumatic event, the Medical Examinational Lamonilled at ance.		Paula Ann Reed	(SISTER)		2514	1 Sec	reta	riate	Dr.	Hollvw	ood.	Marv1	and 20636
ē,	Hea Hea Hea Hea Hea Hea Hea		20a. Method of Disposition		20b. P	lace of Dispo emetery, crea	sition (Nam	ne of		_			cation - City or	
Baltimore,	age: ent of st: If i		1 ☐ Burial 2 🕅 Cremation 3 i 1 ☐ Donation 5 ☐ Other (Spec		# I	insfie:			) .		-	Char	·lotto I	Hall, MD
量	artme orter injur		21. Signature of Funeral Service Lice		- DIT									ome, P.A.
Ba	permit. Departr Importe any inj		David A. Goff		MΩ 1	C-400								land 20650
	1 3 3 3 3 T		23a. Part1. Enter the disease, or conshock, or heart failure. List only										, , , , ,	Approximate
	Physician /Medical Examiner	-	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due to (or as	a consequ	uence of):					ديلرا			Interval Between Onset and Death
	ed sit	nin	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	261106 01).								
	sate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequ	uence of):								
8760,	siciar buris	icalE		d										
687	ficate phys	odic		0										
О. Вох	The law requires that the death certificate be executed the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pro					2	23d. Date of del Month	ivery Day Year
Records, P.	uires that the de signed by the a id be detached f	by	Part II. Other significant conditions	contributing to death bu	ıt not reşı	ulting in the u	nderlying ca	ause give	en in Part I.		-		se contribute to	the cause of death?
COL	w requir been si should	lete									24a. Was a	0	24h Ware au	topsy findings available
_		Completed									autops	V	prior to death?	completion of cause of
Vital	Physicien: this certificatal director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only on			
of	Phys this ral di	5	1 Yes 2 No 27. Manner of Death	1 _ Inpatie		ER/Outpatier 28b. Time o		A	4 🔲 Nurs	sing Home	<ul> <li>5 Resident</li> <li>d. Describe ho</li> </ul>		Other (Spec	cify)
UQ	ding F h. After funera	tion	1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	Injury	м	8c. Injury Work	?` ∕es 2∐No		G. 20001120 110	,,,,,,,,	00001100	
Division	Attending r death. ector: After by the fune	Certification:	2 Accident investigate 3 Suicide 6 Could not	De Diese et leis	inv - At ho	me farm str					f Location (St	reet and	d Number or Ri	iral Route Number.
<u>&gt;</u>	or A after Direction by	ertif	4 Homicide determined	building, etc	. (Specify	()	est, lactory	, OIIICO		20	City or Town			rai noute Number.
7	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examinal	wledge, deat	h occurred a	at the tim in my op	e, date and inion, death	place, and occurred	d due to the ca at the time, d	ause(s) ate and	and manner as place, and due	stated. to the cause(s)
	thin the	Mec	29b. Signature and title of certifier	and manner sta	teu.		29c	. License	number		2	9d. Date	a signed (Monti	n. Dav. Yearl
	N N N	-	· nn 1	17 0			230	_		71				
,	100	i ii	, I pura	toch	wed	7		V	35	16		Nov	ember 2	23, 2004
d	IN	111	30. Name and address of person who Michael Finger					Venii	e Relt	timor	e. Mar	vlar	nd 21224	4
	Sta	i ito	31. Date filed (Month, Day, Year)	32. Redistra			CIII A	· CIIU	Dari	- Inol	c, mar	,		
	Registi		NOV 24			19	Laste	-						

			For State Registrar	State of M	aryland / De	epartment of the control of the cont	Health and M	lental Hygi	ien2004	38117
		•	Decedent's Name (First, Middle,	Last)		ortinioato or	Douin	2. Date of Death	ng. No.	3. Time of Death
	Physical /Media		Thelma	Weiss	Aiken			Month November	Day Year	
	Examir		4a. Facility Name (If not institution,	give street and number;	)	4b. City, Town,	or Location of Death		4c. County of Dea	
			Solomons Nur	sing Center	r	So1	omons		Cal	vert
	Funeral		5. Social Security Number	5. Sex 7. Ag	ge (In yrs. last birth	Months Days		8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign
	Director		577-01-4306	10 M 2 2 1	93 Yr	S.		July 26,		
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Marylan f show ik d at	ō	Many land St	Mary's		по11.	a d			1 ☐ Yes 2 ♣ No
	772 hours after death with the Maryland "netural", or items 23e or 28e-f show offical Examiner must be nulliked at	Director	Maryland St. 10e. Street and Number	nary s		Holly 10f. Zip Code	/wood	10	g. Citizen of What C	ountry?
	3e ou	0	44786 Three Co	vec Road		20	0636		United St	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of H If Yes, specify Cub			14. Race - Am	erican Indian,
9	after or ite		1 Never Married 2 Marrie		No			Rican, etc.)	Black, Whi	,
93	rai', c	l by	3  Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: W.	nite
215-0036	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. D	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	pation during most of worki	na 1	6b. Kind of Business	/Industry
121	within ene. then	ldm	Elementary/Secondary (0-12)	College (1-4or	5+)					
121	filled v Hygie other t		17. Father's Name (First, Middle, L.	4	Di	sbursing C		/Fires Adidate 14	U.S. Gove	ernment
and	hall had the	Be					18. Mother's Name		iaiden Sumame)	
Maryland	should nd Men marke ımetic	2	Herman Wm. Wei		10h l	lailing Address (Street	Bozena		0.4 T	T- 0-1-1
Ma	d 2 s th an 7 ie treu		Carol Heather A							
	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 le marked other then 'it or other treumetic event, I'le Me	1.6	20a. Method of Disposition	rken serb /	20b. Place of D	10 Three Consistion (Name of			OOd Mary . Oc. Location - City or	
Baltimore,	ages int of t: If it		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			crematory or other pla eld-Echols	· /		harlotte H	
Ħ	permit. Page Department of Importent: If any injury of once.		21. Signature of Funeral Service Li		DETHIST					
Ba	Depa Impo any i		Edward N. Brins	field. yr.	M00052				Funeral H	
	100 800		23a, Part1, Enter the disease, or o	omplication that cause	d the death. Do not					20650-0279 Approximate
	Physician		shock, or heart failure. List o Immediate Cause (Final		Company of the Compan	artery	choeas	0		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	GI.	a consequence of)		onsea s			
	Examiner				U	U				
		je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of)	:				
	executed n and ial-transit	Examin	Cause (Disease or injury that initiated events	c						
ó	an and rial-tra	Exa	resulting in death) Last	Due to (or as	a consequence of)					
9289	ite be iysici ne bu	ical	1	d						
	eath certificate be attending physicia for use as the bur	Physiclan/Medical	IF FEMALE:							
Вох	ith ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Petal death	3 Ectopic pregnance	v		23d. Date of de	*
O. E	O O	sic	1 ☐ Yes 2 ☐ No	4☐Pregnant a 9☐ Unknown	t time of death	5 Other (specify)			Month	Day Year
Ρ.	ac ac	Phy	9 Unknown					00 000		
S,	ires that signed to be det	by	Part II. Other significant condition	s contributing to death to	out not resulting in the		en in Part I.		acco use contribute to	
orc	w requir been si should I	ted	- Unamic	- ·	Poocoos			T LI Yes	s 2 □ No 3 □ Pr	obably 4 2 Unknown
Records,	e law has b	Completed	typerien	zon,	<u>V</u>			24a. Was an autopsy	prior to	topsy findings available completion of cause of
H H		Cor	0,					performe		2 🗆 No
Vital	Phyeicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hamitak			26. Place of Death	(Check only one	)	
of	S S	5	1 ☐ Yes 2 ☑ No	Hospital:	1		4 Nursing Hor		ice 6 Other (Spe	cify)
	Jing I	lo	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 28b. Tim uy Year) 28b. Tim Inju	ry Wor		8d. Describe how	v injury occurred	
isi	Attending r death. sctor: After by the fune	icat	2 Accident investiga 3 Suicide 6 Could no	t be an Black of Ini	ius. At homo form		Yes 2 □No	19f Location (Stro	not and Alumbas as Co	and Courts Alicenters
Division	i or Attending I after death. Director: After I in by the funer	Certification:	4 ☐ Homicide determin	ed 286. Place of in	tc. (Specify)	, street, factory, office	4	City or Town,	eet and Number or Ru State)	irai moute ivumber,
_	o the Hospitel or Attending Phithin 24 hours after death. o the Funerel Director: After the ompletely filled in by the funeral		29a. Certifier 12 Certifying	Physician: To the best	of my knowledge o	eath occurred at the tir	me date and place of	nd due to the car	lea/s) and manner	stated
	24 hc 24 hc 8 Fun etely	Medical		caminer: On the basis o and manner st	f examination and/o	r investigation, in my o	ppinion, death occurre	ed at the time, date	e and place, and due	to the cause(s)
	ro the vithin 2 or the complet	Me	29b. Signature and title of certifier	l		29c. Licens	e number	290	d. Date signed (Monti	n. Dav. Year)

To the within To the Comple

DHMH 17 Rev 1/2001

State Registrar

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SSA

31. Date filled (Month, Day 20ar)

32. Registar's Signature

DO59409

Dr. Charlotte

MO 20622

11-24.04.

31. Date filed (Month, Day, Year) State Registrar

111 Penn Street, Baltimore, Maryland 21201

NOV 1 8 2004

		Į.	For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of I		nd Mental F	lygiene Reg. No.2	004	38119
	Physici /Medic		1. Decedent's Name (First, Midden Reginald V.					2. Date of Month Nov •	Day	Year 2004	3. Time of Death 5:35 p. M
	Examin		4a. Fecility Name (If not institution Holy Cross Ho	on, give street and number	r)	4b. City, Town, Silver	Spring	gs	Mon	unty of Death tgomery	_
	Funeral Director		5. Social Security Number 229-36-0429 Usual Residence of Decedent	6. Sex 7. A 1 X M 2 □ F	nge (In yrs. last birthday 72 Yrs.	If Under 1 Year   Months   Days		Min. (Month,	Birth Day, Year) 27,193		lace (State or Foreign try) ;inia
	Maryland -f show	tor	10a. State 10b. Count	gomery	10c. City, Town or L Silver					11	0d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hyglene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be indiffied at ance.	by Funeral Director	10e. Street and Number  1805 Glen Par	k Drive	t Ever in H.C. 12	10f. Zip Code 20902		in? /Specify Vos or	U.S	.A.	
920	ours after de ral', or Item Examinar	by Fune	11. Marital Status  1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	Armed Forces	ĮNo	1 ☐ Yes 2 ☐ No		in? (Specify Yes or Puerto Rican, etc.)		Black, White, ecity: Blac	etc.
21215-0036	within 72 ho ane. than "natur he Medical	Completed		ent's Education lest grade completed)  College (1-4o	r 5+) (Giv	edent's Usual Occu e kind of work done DO NOT use retire ruck Driv	during most	of working	16b. Kind	of Business/Inc	dustry
Maryland 2	uld be filed fental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle Norvell C.And		1 1	IUCK DIIV	18. Mother	's Name (First, Mide Le Riley			
	and 2 shouselfh and Mn 27 is mail		19a. Informant's Name/Relation Jeannette Ander		180	5 Glen Pa		or Rural Route Nur ,Silver S	Springs	,Md.209	02
Baltimore,	Pages 1 ment of He tent: If Iten jury or oth		20a. Method of Disposition  1 Durial 2 Cremation  4 Donation 5 Other	(Specify)	Ft.Linc	oln Cemet	tery 1			ion - City or To	
Ball	Departiment Important Impo		21. Signature of Funeral Service 21. Signature of Funeral Service 22. Part 1. Enter the displace.	Bell	6	22. Name and Addr 503 01d I	Branch	Bell Fund	le-Hil	-	Approximate
	Priysician /Medical	0 1	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	st only one cause on each	Arrhythmi			a. dao or roopilator	, 4.11 0 5.1,		Interval Between Onset and Death
8760,	eath certificate be executed attending physician and for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	Severe Mi s a consequence of):	tral Regi	ırgitat	ion			
.O. Box 68	0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnanc □ Other (specify)	су		23d	l. Date of delive Month	ry Day Year
Δ.	w requires that lhe been signed by th should be detache	ē	Part II. Other significant condi	tions contributing to death	but not resulting in the	underlying cause g	iven in Part I.				e cause of death?
l Records,	The law of the base by page 2 sh	Completed						pe	fas an 2 itopsy enformed? s 2 \( \overline{N} \) No	prior to cor death?	osy findings available inpletion of cause of
n of Vital	Physiclan: r this certific ral director,	To Be	25. Was case referred to medic examiner?  1 Yes 2X No  27. Manner of Death  1X Natural 5 Penc	Hospital: 1 ☐ Inpa		ent 3 DUA	ther: 4 🗆 Nur	of Death (Check on sing Home 5 R 28d. Descrit			/)
Division	or Attendition death	Certification:	2 Accident inves	id not be 28e. Place of	Injury - At home, farm, s etc. (Specify)		⊒Yes 2⊡N	28f. Locatio	n (Street and N Town, State)	lumber or Rura	l Route Number.
	the Hos in 24 h the Fur npletely	edical	(Check only 2   Medica	ying Physician: To the be el Exeminer: On the basis and manner	of examination and/or i	nvestigation, in my	opinion, deat	d place, and due to the time occurred at the time	ne, date and pla	ace, and due to	the cause(s)
	To To Cour	M	29b. Signature and title of certification of certification of the certification of person of per	Honore to	(cus m)	DOC	5730	04	290. Date s	14/04	Jay, rear)
K	(5)	ate		ulakis MD,10			.,Kens	inston,Md	. 20895		
	Regist		NOV 17		w # Ap	onle					

		•	For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of H rtificate of L	ealth and M Death		11e2e0 0 4	38120
	Dhuaiai		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	
	Physicia /Medic			ADDISON				NOV.	10, 2004	2.30 A <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, give s				Location of Death		4c. County of De	
			Shady Grove Adv  5. Social Security Number 6. Sex			RO If Under 1 Year	ckville	8. Date of Birth		GOMERY
	Funeral Director			M 2□F 75	Yrs.	Months Days	Hours Min.	(Month, Day Apr.	26,1929	rthplace (State or Foreign Country) Maryland
			Usual Residence of Decedent					TIPL .	20,1343	riar y rana
	yland		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	ea-f.	cto	MD Montgo	mery	Ro	ckville				1 XYes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	•
	ath w	E .	70 Moore Driv		10 112		0850	acifu Vas or No-	U.S.	
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene dither than "natural", or items 23a or 28a-f show do ther than "natural", or items 23a or 28a-f show event, the Madical Examinant man be notified at	by Funeral Director	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	Rican, etc.)		
ဝို	2 hou	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occupa	ation	ina	16b. Kind of Busines	s/Industry
215		nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired		,,,,	Montgom	_
	filed wil Hygien Sther th ent, the	Son	7th			Laborer		- (E: Nickel)	Governm	ent
nd	be fill ital Hi d oth	Be	17. Father's Name (First, Middle, Last) Winfield Add	dicon				ssie V	Maiden Sumame)	
<u>\S</u>	should be filed within and Mental Hygiene. Imarked other than matic event, the Mental than than the file and	70	19a. Informant's Name/Relationship (Type		10h Maili	na Address (Street			r, City or Town, State	Zin Code)
Maryland	d 2 sl th and 7 is r		Peggy Hackey (							MD 20874
	1 an Heall tem 2		20a. Method of Disposition	206.		osition (Name of matory or other place		Date	20c. Location - City of	
non	A or of		1 Byrial 2 ☐ Cremation 3 ☐ R	pringval ironi otale		Mem. P	(	16/04/	Olne	, MD
Baltimore,	artme orten Injur		21. Sign tuge of Funeral Service Lice	1/0						HOME, P.A.
B	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Is marked any Injury or other treumatic espice.	1	Merger D	Lowella					kville, I	•
			23a. Part1. Enter the disease, of compli- shock, or/peart failure. List only or	cations that caused the dea	n. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Pnysician	12 N	Immediate Cause (Final disease or condition	A 1		thing				Onset and Death
	/Medical		resulting in death)	Due to (or as a conse	quence of):					1
	Examiner		Sequentially list conditions, is any, recalling to minipolate	Due to for as a consa		mia				hours
	pe ils	iner	cause. Enter Underlying Cause (Disease or injury		no 508	513				days
_	and al-tran	Examin	that initiated events resulting in death) Last	Due to (or as a conse	100					3
68760,	cate be executed physician and the burial-transil			4						
687	= 40	edicai								
O. Box	at the death certifi by the attending parties as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3[	☐Ectopic pregnancy ☐ Other <i>(specify)</i>	,		23d. Date of d Month	elivery Day Year
0	de de		Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds,	uires sign lid be	d by						1 🗆 Y	res 2 □ No 3 □	Probably 4 Minknown
Record	w requ	Completed						24a. Was		autopsy findings available
Re	The lav	то						autop perfo	rmed? death'	completion of cause of es 2 No
Vital		a	25. Was case referred to medical				26. Place of Deat			
$\geq$	Physicien: this certific ral director,	To B	examiner? 1 Tes 2 M No	Hospital: 1 ☐ Inpatient 2¶	ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing Ho	ome 5 Resid	lence 6 □Other (Sp	pecify)
on of	ding After fune		27. Manner of Death 1 ■ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	y at k? Yes 2 □ No	28d. Describe h	now injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec		reet, factory, office		28f. Location (5 City or Tox	Street and Number or i m, State)	Rural Route Number.
	To the Hospita within 24 hours To the Funerel completely filled	Medical (		sician: To the best of my kr ner: On the basis of examin and manner stated.						
	To the Within To the comple	Me	29b. Signature and title of certifier	-		29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
)	1					038	8847		11100	4
	6		30. Name and address of person who co			, Print)				(
			David Klein,			Center	Dr., R	ockvil	le, MD 2	0850
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  NOV 1 8 200	32. Registrar's Sign	nature	Louds				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 10, 2004 **Physician** 4:20 pM JOHN ATKINSON, JR. ROLLINS /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Citizens Nursing Home 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F Yrs. 4-11-1928 Washington D.C. 76 Director 216-22-8322 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b County r than "natural", or items 23e or 28e-f ehow the Medical Examinar must be notified at 1 Yes 2 □ No Frederick MD Frederick Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21702 U.S.A. 1900 Rosemont Avenue Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 G Yes 2 □ WWII If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married White 1□Yes 2≧No Specify 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "r any injury or other traumatic event, the Mad 90s. Elementary/Secondary (0-12) Coltege (1-4or 5+) Telephone Repair & Install Bell Telephone Co. 12th 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Mary Marceline Smith Rollins John Atkinson, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 606 Apple Ave. Frederick, Maryland (wife) Polly Atkinson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ♣ Donation 5 ☐ Other (Specify) Resthaven Mem. Gards 11-15-04 Frederick, Md. 21. Signature of Juneral Service License 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. Market St. Frederick, Md. 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock; or heart failure. List only one Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** decel reumoner /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.O. should be detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Ser certificate 1 ☐ Yes 2 NO 25. Was e referred to medical examiner? 26. Place of Death Check onl one Other: Hospital: 1 ☐ Yes 2 ☐ No 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 1 Inpatient Certification: To this funeral 27. Manner of Death 1 ☑Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) After 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. | Director: Af 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely the 29b. Signature and title of certifier 30. Name and address of person who completed 0+1 Mon als 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

			For State	State of Maryland /	-			nd Mental Hy	ygiene n n	4 38122
			State Registrar  1. Decedent's Name (First, Middle, La	et)	Cei	tificate of	Death	2. Date of D	Reg. No.	3. Time of Death
п	Physicia	an	Harold (NMN) Bart					Novemb	Day Y	'ear
	/Medic Examin	al -	4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of I		4c. County of	
	LAGIIIII		Homewood at Cruml	and Farms		Frederic	ck		Frederi	ck
	Funeral		5. Social Security Number 6. S	7. Age (In yrs. last b		If Under 1 Year Months Days		Min. (Month, D	irth (Say, Year)	Birthplace (State or Foreign Country)
	Director		144-18-6514 Usual Residence of Decedent	81	Yrs.			0ct. 1	5, 1923 N	ew Jersey
	land low		10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
	B-1st	ctor	Maryland Frederic	k Frederi	ick					1 ☐ Yes 2 🕅 No
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	s 23a	erai	7407 Willow Road	12. Was Decedent Ever in U.S.	12 1	21702	disponio Origin	n? (Specify Yes or N	USA	American Indian.
	Iter de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No		f Yes, specify Cub	an, Mexican, f	Puerto Rican, etc.)		White, etc.
Maryland 21215-0036	within 72 hours after death with the Maryland one. than "natural", or Items 23a or 28a-f show than "natural" or Items 1.a Modical Exacultural or items.	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1∐Yes 2XINo	Specify:		Specify:	Vhite
ည်	72 ho	Completed	15. Decedent's E (Specify only highest gra		a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most o	of working	16b. Kind of Busin	ness/Industry
121	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+) 5+ N1		oo not use retire ar Physic	•		HC Needs	ar Research Ctr
р Б	filled v Hygie other t	e Co	17. Father's Name (First, Middle, Last		тсте	ar FllySic		s Name (First, Middl	e, Maiden Sumame)	
an	ld be lental ked c	B	Albert Anton Emil	Bartz			Frieda	Bartz		
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Exercitment unit be neithed at once.	-	19a. Informant's Name/Relationship (		9b. Mailir	ng Address (Street			ber, City or Town, St	ate, Zip Code)
	and 2 ealth in 27 I		Katherine Bartz, o					Frederick	*	
ore	ges 1 t of Ho if iter or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐			sition (Name of natory or other pla		Date	20c. Location - Ci	
Baltimore,	t. Partmen	7	* 4 □ Donation 5 □ Other (Special					/24/2004		k, Maryland
Bal	Departing Department of the poores.		21. Signature of Funeral Service Lice	DUSA MO099	99 10	06 East (	Church	Street, F	rederick,	Funeral Home MD 21701
			23a. Part 1. Enter the disease, or comshock, wheart failure. List only	plications hat caused the death. Do	o not ent	er the mode of dyi	ng, such as ca	ardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician	i n	Immediate Cause (Final disease or condition resulting in death)	a Pneumonia						12 Days
	/Medical Examiner		resulting in dealin)	Due to (or as a consequence	e of):					
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9 xo	death certific e attending pl ed for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnancy					23d. Date of	of delivery
Bo	leath atten	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pregnanc Other (specify) _	У		Month	
P.0.		hysi	9 Unknown	9□ Unknown						
	96 JB	by P	Part II. Other significant conditions		j in the u	nderlying cause gr	ven in Part I.			ute to the cause of death?
ord	w require been si should l		Alzheimers Diseas	se				1	Yes 2 X No 3	☐ Probably 4 ☐ Unknown
Records,	e law I has b	Completed	Melanoma						opsy pric	ore autopsy findings available or to completion of cause of ath?
a F	Th ate pag							1 ☐ Yes	2 X No 1 □	Yes 2□No
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🎖 No	Hospital: 1   Inpatient 2   ER/0	Outnation	t 3 DOA		ing Home 5 Res	sidence 6 Other	(Specify)
0 l	g Phye er this eral di	<del> -</del>	27. Manner of Death		. Time of Injury				how injury occurred	
ion	Attending Property.  r death, ector: After to the funerance.	atlo	1 XNatural 5 Pending 2 Accident investigation	on	injury		Yes 2 □ No			
Division	or Atterde	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		farm, str	eet, factory, office			(Street and Number own, State)	or Rural Route Number,
	pital c		One Continue of Continue B				data and	alass and due to the		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical		hysician: To the best of my knowled miner: On the basis of examination and manner stated.						
	To the within To the complete	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (	Month, Day, Year)
	1.		Mary P.	Howeeon	W	D4607	<b>'</b> 5		November 2	22, 2004
	3		30. Name and address / person who	completed cause of death (Item 23a	a) (Type,	-	T7 1	mi al- am	21702	
			Mary P. Howell, MI 31. Date filed (Month, Day, Year)	32. Registrar's Signature	nnso	on urive,	rreae	IICK, MD	21702	
	Sta Regist		DEC 0 2 200	d.	4	Same	~			
			0 % 200			May 1 the stay	#			

			For State	State of Marylar					/ 11111	38123
			Registrar	1	Cei	rtificate of L	Jeam	2. Date of Dea	10g. 110.	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last					Month	Day Year	
	/Medic	al	MILDRED ANNA B			4b. City, Town, or	Logation of Do		21, 2004 4c. County of Deat	9:45P M
	Examin	er	4a. Facility Name (If not institution, give					atti		
	<del></del>		3238 JENKINS L. 5. Social Security Number 6. Se		last birthday)	INDIAN If Under 1 Year	If Under 24 H	rs. 8. Date of Birth		RLES
	Funeral Director			M 21XF 84		Months Days	Hours M			hptece (State or Foreign buntry) COLORADO
			Usual Residence of Decedent					10111.2	.5/1520	
	ylan		10a. State 10b. County	10c. Ci	ty, Town or Lo	ecation				10d. Inside City Limits
	a-f.s	cto	MARYLAND CHAR	LES	INDI	AN HEAD				1 □ Ÿes 2 ሺ No
	death with the Maryland me 23a or 28a-f show rmust be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	23a	Ta I	3238 JENKINS LA				0640		U.S.	
	teme teme	nne	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
30	hours after tural', or Ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏ Yes 22 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:		Specify: W.F.	HITE
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Ų.		piet	(Specify only highest grad	fe completed)  Coflege (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of v )	vorking	MARYLANI	HOUSE
7 7	filed within 72 Hygiene. other than "nater"	Completed	12	College (1-401 3+)	SEC	RETARY			OF DELEC	
	be filed withi tal Hygiene. d other than event, tre M	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden Sumame)	
<u>a</u>	should be nd Mental marked c	To E	NICHOLIN G. KRA	GH			AGNES	PETERSO	N	,
Maryland	2 sho and ! is ma		19a. Informant's Name/Relationship (T)		1				r, City or Town, State, 2	
	りもとっ		CLARENCE O. KRA		The second distriction		RIVER		GEWATER,	
ore	ges 1 an it of Heal if item 2 or other		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ I	Removal from State	cemetery, crei	sition (Name of matory or other plac	1	Date	20c. Location - City or	Town, State
Ē	Pa ant ury		*4 ☐Donation 5 ☐ Other (Specify,	TRINI		M. GARDI		-24-04	WALDORF,	MARYLAND
Baltımore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	M00479		2. Name and Addres		L SERVIC	E, P.A.	
	405 a d		23a. Part1. Enter the disease, or comp	C. Santiago the ages	I.	Δ ΡΙΔΠΔ	MARY	I.AND 20	1646	Approximate
Н			shock, or heart failure. List only o	ne cause on each line.		,		ac of respiratory an	1651,	Interval Between Onset at d Death
	Physician		Immediate Cause (Finaf disease or condition resulting in death)	a LUPE		AMCI				
	/Medical Examiner			Due to (or as a consec	quence of):					
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9	tifical ig phy as th	ledi								
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Э.	be dea	sici	in the past 12 months?	4☐Pregnant at time of e	death 5[	Other (specify)			World	Day
<u>о</u>	that the death certifical ed by the attending phi detached for use as th	by Physician/Med	9 Unknown				in Dard I	22a Did to	bacco use contribute to	the sauce of death?
Ś	signed I		Part II. Other significent conditions co	ontributing to death but not re-	suiting in the u	inderlying cause give	en in Parti.			obably 4 Urknown
Records,	w requir been si should i	Completed						*	-ext gyet	
ec	has b	nple						24a. Was autop	sy prior to	topsy findings available completion of cause of
<u> </u>	: The	S						1 ☐ Yes	2□/10 1□Yes	2 □ No
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		ot aclock Oth	O.C.	Death (Check only o		
o	Phys this ral dii	٠ <u>.</u>	1 Yes 2 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie	II 3LI DUA	4 🗆 Nursing		lence 6 Other (Spe	city)
on	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 ☐ No			
Division of	deat deat ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - Ath	ome, farm, st	reet, factory, office			Street and Number or Ru	ural Route Number,
2	after Dire	Certification:	4 Homicide	building, etc. (Spec	ify)			City or Tow	m, State)	
	hours mere y fille		29a. Certifier 1 certifying Phy	sician: To the best of my kn	owledge, deal	h occurred at the tin	ne, date and pla	ace, and due to the	cause(s) and manner as	stated.
	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death.  To the Funerel Director: Atler this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it	Medical	(Check only 2 Medicel Exam	iner: On the basis of examin and manner stated.	ation and/or in	ivestigation, in my o	pinion, death of			
	To the To the Comp	Σ	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mont	h, Day, Year)
•			1 Matt	~~		07	7-77	7	11/19/	04
	12		30. Name and address of person who o	completed cause of death (Ite	m 23a) (Type	Print) DI	1	Me	1.20	646
	Sta Regist		31. Date filed (Month, Day, Year) DEC 0 2 200	32. Registrar's Sign	ature	Som of	<i>)</i>			

			1 - For Stata Registrar	State of M	larylan		artment of F		nd Mental H	ygienę Rag. No.	004	381	24
	Physici	an	Decedent's Name (First, Middle, Las     Jerome			-	Dammatt	C	2. Date of Month	Day	Year	3. Time of I	Death M
	/Medic Examin	al ,	4a. Facility Name (If not institution, give	Way street and number			Bennett  4b. City, Town, o			ber 2	0, 2004 County of Deat	1	
	Examin	er	Memorial Hospital			nter	Cumbe				Allegar		
	Funeral		5. Social Security Number 6. Se	7. A	ge (In yrs.	last birthday)	If Under 1 Year Months Days		4 Hrs. 8. Date of I Min. (Month,		9. Birti	hplace (State or untry)	Foreign
	Director		212-38-6120 13 Usual Residence of Decedent	7 M 5 L	63	Yrs.			05/25		Ma	ryland	
	yland sow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside Cit	
	e Mar Se-f st	ctor	MD Allega	ny		Cun	berland			,		1. Yes	2 🗆 No
	with th	Dire	10e. Street and Number	. Charact	A - 4	Д.1	10f. Zip Code	0.0		-	en of What Co	untry?	
	ns 234	Funeral Director	145 N. Mechan:	12. Was Deceden	Ever in U.		Was Decedent of H		n? (Specify Yes or		JSA 4. Race - Ame	rican Indian,	
9	after d or Iten	Fun	1 Never Married 2XXMarried	Armed Forces	? No	i	If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican,  Specify:	n? (Specify Yes or Puerto Rican, etc.)		Black, White	e, etc.	
21215-0036	within 72 hours after death with the Maryland ene. then 'naturel', or items 23e or 28e-f show fra Masileal Examiner must be mailined at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	195 196	Ŏ					Specify:	White	
15-	n 72 h	Completed	15. Decedent's Ed (Specify only highest grades)	de completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most o d)	of working	16b. Kin	d of Business/	Industry	
212	e filed within at Hygiene. I other then "	omi	Elementary/Secondary (0-12)	College (1-4or	5+)	1	ustodian			Se	ervice	C1ub	
nd	al Hyg	BeC	17. Father's Name (First, Middle, Last)			ъ.			s Name (First, Midd				
yla	2 should be and Mental le marked ore	<sup>2</sup>		atson		Bennet			ginia	Maı		lan	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 Is marked other then "naturel", or items 23e or 28e-f show or other treumetic event. It a Marital Examinet must be malliad at		19a. Informant's Name/Relationship (7 Jerome W. Bennett		n		-		or Rural Route Nur eet, Cumb			21502	
re,	of Health item 27 other tr	- 6	20a. Method of Disposition			Place of Disponentery, cre	osition (Name of matory or other place	ce)	Date	20c. Loc	ation - City or	Town, State	
imo	Page ment c ent: If ury or		1 ☐ Burial 2 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify			mberla	ind Cremat	tory 1	1/20/2004				
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny Injury or ot once.		21. Signature of Juneral Service Licen	- acle	يسسعسد	2			Adams Fa Street, C				
	75		23a. Part1. Enter the disease, or composhock, or heart failure. List only	lications that cause one cause on each	d the deat	h. Do not en	ter the mode of dyir	ng, such as ca	ardiac or respiratory	arrest,		Approximate Interval Betw Onset and D	reen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				AR F	IBRI	TALL	. N.		Oriset and D	
	Examiner			Due to (or a	s a conseq	uence of):							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a conseq	uence of):							
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a		Lionan of):							
8760,	death certificate be executed e attending physician and by for use as the burial-transit	al E	l	d Due to (or a	s a conseq	derice or).							
9	rtificate ng phys as the	Medical	IF FEMALE:										
Вох	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant :	2 🗌 Feta	Ideath 3[	☐Ectopic pregnancy ☐ Other (specify)	/		2	3d. Date of deli Month	,	ear
o.		yslo	1 Yes 2 No 9 Unknown	9□ Unknown	at thine of d	94(1) 5[							
Δ.	es that the igned by th be detache	by Pi	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	ınderlying cause gıv	en in Part I.	23e. Di	d tobacco us	e contribute to	the cause of de	eath?
ord	w requires been sign should be		COPD						1[	]Yes 2□	]No 3' <b>□-</b> Pf	oBably 4 ∏Ui	nknown
Vital Records,	law as t	Completed		TAILE	NOT	***			24a. Wi	as an topsy rformed?	24b. Were au prior to death?	topsy findings a completion of ca	vailable use of
al	Thate page	e Col	25. Was case referred to medical	BUSE.				00 Diana	1 ☐ Yes	2 No	1 ☐ Yes	2 No	
<u> </u>		0 B	examiner?	Hospital: 1 Inpat	ient 2 🗆	ER/Outpatie	nt 3 DOA Oth	Ar.	of Death (Check online)		☐Other (Spec	cify)	
n of		on; T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	ury ay Year)	28b. Time of Injury	Wor		28d. Describ	e how injury	occurred		
Division	att att	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ium - At h	ome farm et	M 1 □	Yes 2 N		(Street and	Number or Ru	ral Route Numb	nar.
Div	or Attendater death	Certification;	4 ☐ Homicide determined	building,	tc. (Specif	y)	reet, ractory, office			own, State)	7107707 07 770	rai ribato realib	
	To the Hospitel or Atterwithin 24 hours after de To the Funerel Directo completely filled in by the	edical C	29a. Certifier  (Check only 2 Medical Exam	ysician: To the bes	t of my kno	wledge, deal	th occurred at the tir	ne, date and	place, and due to the control occurred at the time	e date and	and manner as	stated.	
	the H	Medi	one)  29b. Signature and title of celtifier	and manner s	tated.		29c. Licens				signed (Month		
	To with		1///	0-		M.D	~	0059	121	11/	1	2004.	
~	la c		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type,			, ~ ,		20/0	(001)	
	1.		Tasneem Mal:				Avenue,	Cumber	land, MD	21502	2		
89	Sta Registi		31. Date filed (Month, Day, Year)  NOV 2 2		trar's Signa		9 Space	1.1					
						/3	- MANGE	12/					

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		200	For State Registrar	State of Mary			of Hea		Mental Hy	/giene /	2004	38126
	Physicia	an	1. Decedent's Name (First, Middle, Last) PATRICIA J.	BOSTV	VICK				2. Date of D Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give str			4b. City. T	own, or Loca	ation of Dea	Novembe		2004 ounty of Death	11:50A M
	Examin	er	St. Mary's Nursing Ce				ardtown			St	. Mary's	
3	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1		Jnder 24 H	n. (Month, D	irth Jay, Year)	Coun	lace (State or Foreign try)
	Director		5/9-54-1424	M 2XIF	64 Yrs.				January	12, 194	+0 Washin	gton, DC
	and DW		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation			-		1	0d. Inside City Limits
	Mary	to	Maryland St. Mary's	] ]	Hollywood							1 ☐ Yes 2 ☒ No
	death with the Maryland ims 23a or 28a-f show r must be notified at	Director	10e. Street and Number			10f. Zip (					n of What Cour	itry?
	ath wi		43112 Coles Road	W- D- d- d		206		in Origin?	(Specify Vac or h	USA	Race - Americ	en Indian
	ltems rerr	Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married	<ol> <li>Was Decedent Ever Armed Forces?</li> <li>1 ☐ Yes 2 \ No</li> </ol>				exican, Pu	(Specify Yes or Nerto Rican, etc.)		Black, White,	etc.
Maryland 21215-0036	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	⊠ No Sp	pecify:		Sp	pecity: Whi	te 
ڻ ص	72 ho natur	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	(Give	kind of work	Occupation done during	g most of w	vorkin <b>g</b>	16b. Kind	of Business/Inc	dustry
121	within then the Man	idu	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT us</i> e lemaker	e retirea)			Own	Home	
2	be filed within 72 hours after death with the Marylan tial Hyglene. Id other than "natural", or Items 23a or 28a-f show event, the Madical Examiner must be notified at	Be Cc	17. Father's Name (First, Middle, Last)				18.	Mother's N	ame (First, Middl	le, Maiden Su	ımame)	
<u> a</u>	hould be id Mental marked matic ev	To B	Louis Nathaniel Robins	on				Marion	Louise Ba	ldwin		
lary	2 sho and N is ma	i	19a. Informant's Name/Relationship (Typ						Rural Route Num		own, State, Zip	Code)
≥ (a)	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a <u>once</u> .		James Anthony Bostwick/ 20a. Method of Disposition					o11ywoo	od, MD 206. Date		tion - City or To	wn, State
00	nt of h		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	20b. Place of Dispo cemetery, cree Charles Mem			Nov	. 30, 2004			
Baltimore,	artme ortan injuri		21. Signature 1 Funeral Service Licenser		^			-	Funeral Ho			
ñ	Ped in a		Thichael Yeves	Huch	Y	.O. Box	x 270.	Leonard	itown. MD	20650	· · · · · · · · · · · · · · · · · · ·	
4.			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line.	death. Do not ent	er the mode	of dying, su	ich as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		atoryte	zi lan	re					
S	Examiner			Due to (or as a co	onsegrence gn	bill.	ita					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as a co	onsequence of):		)		400			
	ate be executed nysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a co	oneoguages of):							
760,	be exelician a	cal E)	l .	Due to (or as a co	orisequence or).							
687	leath certificate t attending physic I for use as the t		d.									
Вох	h certi ending	M/us	23b. was decedent pregnant	ic. If yes, outcome of p		∃Ectopic pre	agnancy			230	d. Date of delive	ory Day Year
e B	e deat	sicis	in the past 12 months? 1 □ Yes = 2 ØNo 9 □ Unknown	4☐Pregnant at tim 9☐ Unknown		Other (spe					WORT	Day Tou.
P.O.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Medi	Part II. Other significant conditions conf	ributing to death but n	not fresulting in the u	inderlying ca	ause given in	Pant I.	23e. Dio	tobacco use	contribute to the	ne cause of death?
ds,	uires n sign	d by	stroke with en	cephalope	my 170	2501	zure	01.80	10	]Yes 2□1	No 3□Prot	ably 4 Unknown
000	aw require s been si	piete	Drabetes mel	lutas on	Insul	In, 6	, (ate	ral (	ef 24a. We	as an		psy findings available mpletion of cause of
Re	sicien: The law certificate has birector, page 2 s	Completed	amputation, 5/6	) ranel	stony,	SIP (	a tub	re ins		rformed?	death? 1 ☐ Yes	2 🔀 No
/ita	cian: ertific	Be	25. Was se referred to medical examiner?	ospital: ,			Other		Death (Check only			
of	Physic this c	To.	1 Yes 2 No	28a. Date of Injury	2 ER/Outpatie		Bc. Injury at	4 V Nursing	Home 5 Re 28d. Describ	sidence 6 [ e how injury o		y)
O	nding th. : After	tion	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear) Injury	М	Work?	2 🗆 No				
Division of Vital Records,	r Atter	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (		reet, factory	, office			(Street and fown, State)	Number or Rura	al Route Number,
Ö	Hospital or Attending Physician: 24 hours after death. Funerel Director: After this certificatiety filled in by the funeral director,											
		Medicai	29a. Certifier 1 Certifying Phys (Check only 2 Medicel Examin	ician: To the best of r er: On the basis of ex and manner stated	amination and/or in	nvestigation,	in my opinic	ade and pla on, death or	courred at the time	e, date and pl	lace, and due to	the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	120	20 0	29c	. License nu	imber	10	29d. Date	signed (Month,	Day, Year)
)			1		m D		V >	1/3	00	1(/	26/2	007
1	teir		30. Name and address of person who co	mpleted cause of deat	th (Item 23a) (Type 2RVBLL	Print)	AN R	D F	to LLYV	NOD	mo	20636
0.	St	ate	31. Date filed (Month) Pay Year) 0 2	32. Régistrar's	Signature	1						
	Regist		1401 6 3 7	1119 A Ballan	- FR. A	200462	B					

				artment of Health and Me		2007 20127
			Decedent's Name (First, Middle, Last)		Reg. No.	3. Time of Death
5.	Physici /Medic		Pauline Berry	No	Month Day	2004 2:00 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c.	County of Death
			6305 Riggs Road #311	Hyattsville		ince George's
L	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 on 1 on 2 on 1 on 1 on 1 on 1 on 1 on	Months Davs Hours Min.	Date of Birth (Month, Day, Year)  ine 8, 192	9. Birthplace (State or Foreign Country) 9. Orlando, Fl.
	pg *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Maryia febor	lor	Maryland Prince George's Hyattsvi			11x Yes 2 □ No
	r 28e	Funerai Director	10e. Street and Number	10f. Zip Code	10g. Citiz	zen of What Country?
	th with	aiD	6305 Riggs Road #311	20783		USA
	r dea	neu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No-	Race - Americen Indian,     Black, White, etc.
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23a or 28e-f ehow or other traumatic event, the Modical Exercitational be profiled at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Black
21215-0036	72 ho	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation  s kind of work done during most of working	16b. Kir	nd of Business/Industry
121	vithin ne. hen *	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
	filed v Hygie other i		5+ School 17. Father's Name (First, Middle, Last)	ol Teacher/Lab Techt 18. Mother's Name (F	nician Nor First, Middle, Maiden	
Maryland	12 should be filed within "h and Mental Hygiene." I's marked other then "fraumatic event, ure Men	To Be	unknown	unkno	own	
lary	2 shou and N Is mai			ing Address (Street and Number or Rural F		
Σ,	and 2 ealth m 27			Hamilton St. Hyatts		
lore	it of H it of H if ite		1 LABurial 2 Cremation 3 Hemoval from State	nmatory or other place)		cation - City or Town, State
Baltimore,	artmer artmer ortant injury					phi, Maryland
Ba	permit. Pages 1 and 2 Department of Health ar Important: If item 27 Is eny injury or other trau 2005.			Mars 217 Ninth Street NW		neral Home, Inc. on DC 20011
b			23a. Parti Enter the disease, or complications that caused the death. Do not er shook, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between Onset and Death
V.	Physician /Medical	ň		ardiovascular Heart	Disease	Ondo, and Doam
	Examiner		Due to (or as a consequence of):			
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (of as a consequence of).			
	rcuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
8760,	icate be executed physician and s the burial-transit	i Ex	resulting in death) Last Due to (or as a consequence of):			
687	icate l physi s the b	edicai	d			
ox (	death certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	7	2	3d. Date of delivery
m	ne death the atte	Physician/M	In the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year
P.0	that the di ed by the detached	Phys	9 U Onknown	and the second second	22a Did tabassa u	se contribute to the cause of death?
ds,	Se US	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 Yes 2	
Records,	w require been signature	Completed			24a. Was an	24b. Were autopsy findings available
Re	sician: The law certificate has b irector, page 2 s	omp			autopsy performed?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vital		Be C	25. Was case referred to medical	26. Place of Death (C		12100 2210
of V		10	exampler?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpaties	nt 3□ DOA Cther: 4□ Nursing Home	5 Residence 6	Other (Specify)
n c		ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury 1 ☐ Natural 5 ☐ Pending (Month, Day Year)	Work?	d. Describe how injury	occurred .
Division	r Attendir er death. rector: Al by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		Location (Street and	f Number or Rural Route Number,
Ο̈́	s after	Certification;	4 ☐ Homicide determined building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, State)	
	Hospit t hours unere		29a. Certifier (Check only (Ch			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attencompletely filled in by the fune	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number		signed (Month, Day, Year)
	F 3 F 8		Abodo Aleta &			-
	(W)		30. Name and address of person who ompleted cause of death (Item 23a) (Type	, Print)	, 0	rember 11,2000
4	9/		Siderader Solvetar, 3001 Hosp	pital Drive C	lovery,	may/ and
	Sta Registi		31. Date filed (Month, Day, Year)  NOV 1 7 2004	•	<i>V</i> (	
	negisti	CII .	MUN I 7 LUU4 Bloke & April			

State of Maryland / Department of Health and Mental Hygien 2004 38128 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Joseph November 2004 | 10:14PM M Bruzzese Α. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 516 Balboa Avenue Capitol Heights Prince George's If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 € M 2 □ F 579-03-4724 86 Director 10,1918 Washington, Aug. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importants it liems 23e or 28e-f show Importants it liems 27 is marked other than "natural", or flems 23e or 28e-f show any injury or other treumsite event, it is hadical Exertinated by northing and in the most of the provided and the provi 1 ☐ Yes 2 ☑ No Maryland Prince George's Director Capitol Heights 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 516 Balboa Avenue 20743 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Park Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bruzzese Guisseppi Geroloma Sorento 흔 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Donna Bruzzese 516 Balboa Avenue Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. T7. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 2004 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6633 Old Alexandria Ferry Road Clinton, MD 20733 rounce m001284 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Interstitial Pulmonary Fibrosis 3 years /Medical Due to (or as a consequence of): Examiner Rheumatoid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician thed for use as the buria Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 □Unknown 1 Tes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 2 No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 No Certification: To 1 Yes 4 Nursing Home 5 X Residence 6 □Other (Specify) filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ö To the Hospital o 7.24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00012015 11-15-2004 Tember who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Louis Stienberg M.D. 6492 Landover Road Suite D Landover MD 20785 31. Date filed (Month, Day, Year)
NOV 1 7 2 . Registrar's Signature State 2004 Registrar

		•	For Stete Registrer	State of Ma	ryland / Dep	artmen	t of Health and e of Death	Mental Hyg	iene 2001	38129
			Decedent's Name (First, Middle, Last	)		,		2. Date of Dea		3. Time of Death
П	Physici		ARTHUR PHILI	P BECKEI	₹			NOVEMBE	R 13, 200	
	/Medio Examin		4a. Facility Name (If not institution, give			4b. City,	Town, or Location of Deat		4c. County of De	
	Examin	le:	5915 ONONDAGA ROA			В	ETHESDA		MONTGO	OMERY
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	If Under				irthplace (State or Foreign Country)
100	Director		Usual Residence of Decedent	X <sup>M 2□ F</sup> 86	Yrs.	Months	Days Hours Min.	AUG 4,	1918 NE	V YORK
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ahow any injury or other traumetic event, the Medical Examinar hust be neithed at any injury or other traumetic event, the Medical Examinar hust be neithed at any injury or other traumetic event, the Medical Examinar hust be neithed at any injury or other traumetic event.	_	10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
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	or 28	Director	10e. Street and Number			10f. Zip		1	0g. Citizen of What 0	Country?
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	r deg	by Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Deced If Yes, spec	lent of Hispanic Origin? (S ofy Cuban, Mexican, Puer	ipecify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
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	Hygie ther ant, II	ပိ	17. Father's Name (First, Middle, Last)		Titton	TIDOI		me (First, Middle, i		EL BLVEGOTTEN
an	ontal ed o	Be c	SAMSON VICTO	R BECI	KER		MINNA	•	GREENBERGI	₹R
Maryland	should be tand Mental I semarked o	2	19a. Informant's Name/Relationship (T)			na Address	(Street and Number or Ri			
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é,	1 and Health Iem 27		20a. Method of Disposition	, 5011	20b. Place of Disposemetery, cre			The state of the s	20c. Location - City of	r Town, State
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Baltimore,	it. Purtme		<ul> <li>4 □ Donation 5 □ Other (Specify,</li> <li>21. Signature of Funeral Service Licens</li> </ul>					The second secon	OLNEY, MAI	
Ba	permit. Departi Importi any inj		1	4	Ď	ANZAN	d Address of Facility SKY-GOLDBERO	MEMORIA	L CHAPELS	, INC.
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	/Medical Examiner				a consequ <i>e</i> nce of): . <b>R HEART D</b>	CCT A CT				10 WEARG
		1	Sequentially list conditions,	b	a consequence of):	LOEADI	<u>'</u>			12 YEARS
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	ate be executed nysician and he burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequence of):					
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Φ.	that the de led by the a detached		Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the u	ınderlying c	ause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds	w requires that been signed to should be det	Q P	DILATED CARDIOMY(	PATHY				1 🗆 Y	as 2∭XNo 3∏F	Probably 4 Unknown
Ö	w req beer shou	lete	SUBACUTE BACTERIA		DITIS			24a. Was a	n 24b. Were a	autopsy findings available
Records,	ne lav s has ge 2	Completed by	ATRIAL FIBRILLAT	EON				autops perform	ned? prior to death?	completion of cause of
a			25. Was case relerred to medical				00 Plans of Pa			s 2 No
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o	> 0 0	: To	27. Manner of Death	28a. Date of Injur (Month, Da)			8c. Injury at		ow injury occurred	өспу)
on	ding F h. After funer	ţ	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	м	Work? 1 ☐ Yes 2 ☐ No			
Division	Attending r death. sctor: After y the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be	289. Place of inju	ıry - At home, farm, st	reet, factory	, office		reet and Number or F	Rural Route Number,
Θį	lor/ after Dire	erti	4 Homicide	building, etc	c. (Specify)			City or Town	n, State)	
	To the Hospitel or Attending Ph within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral	Medical C		iner: On the basis of	examination and/or in		at the time, date and place, in my opinion, death occ			
	thin 2 thin 2 the	Mec	29b. Signature and title of certifier	and manner sta	ned.	290	c. License number	2	9d. Date signed (Mor	nth, Day, Year)
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7	20		white !.	Hercirl	K M D	4	D0005585		NOVEMBER 1	4, 2004
			30. Name and address of person who con GILBERT HURWITZ,				LI LIACUTATORON	ממני מת ד	0.6	
	- 04			32. Røgistra	ar's Signature	0		v, μυ 200	טט	
	Sta Regist	ate rar	31. Date filed (Month Day, Year) NOV 16 20	04 Bens	va B	20	acks!			

Registrar

State of Maryland / Department of Health and Mental Hygiena For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5:05 A M Day Month Veer **Physician** Ruth BERG 15 November 2004 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Nursing Center 8. Date of Birth 1918 (Month, Day, Year) January 27, Leonardtown Mary's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 X F 86 161-01-3639 Director PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "naturel" or items 23a or 28e-f show eny injury or other treumatic event, it a Wedical Examination with the multiple at 10d. Inside City Limits 10c City Town or Location 10a, State 10b. County 1 XYes 2 No Maryland St. Mary's Hollywood Director Street and Number 10f. Zip Code 10g. Citizen of What Country? 44633 Joy Chapel Road 20636 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married t Yes 2 No If Yes, Give Year or Dates: Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benne Slutzsky Ida Beizer ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Berg / son 44633 Joy Chapel Road, Hollywood, MD 20636 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cametery, crematory or other of Date 20c. Location - City or Town, State PA Shalom Memorial Park Nov.17,2004 Lower Moreland Township b \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licentee Michael 254 Carroll St., NW, Washington, DC 20012 d. Approximate Interval Between Onset and D 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on yich line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner are Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequen Examiner The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not result | g in the unverlying cau | e given in Pa 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No the Hospitel or Attending Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 3 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Chis 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel ( 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ME 30. Name and address of person who completed cause of death (Item 23a) (Type-Print) 2/4035 Three Notch Rd., 0. Box 640, Hollywood, MD 20636 James MD. Jarboe, onth, Day, Year) 32. Registrar's Signature 31. Date filed (M State 16 2004 Registrar

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Registrar

Richard Leon

			1 - For State Registrar	State of	f Marylan		artment tificate			ind M		giene		38134
	Physici /Medic		1. Decedent's Name (First, Middle, Caroline Ri	efle Be							2. Date of Dea Month Nov 11	Day	04	3. Time of Death 810 A M
	Examin		4a. Facility Name (If not institution, Asbury So	omons H	ealth		Sol	omo					Calve	
	Funeral Director		5. Social Security Number 215 10 6249  Usual Residence of Decedent	3. Sex 1 □ M 2√2 F	7. Age (In yrs. 90	/ast birthday) Yrs.	If Under Months	Days	If Under a	Min.	8. Date of Birt Month Da DeC 21	<sup>1</sup> 791/3	9. Birthp Mary	lace (State or Foreign Land
	Maryland a-f show	tor	10a. State 10b. County Maryland Calve	rt	10c. Cit	y, Town or Lo Solomo							1	0d. Inside City Limits 1 □ Yes 2 No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 11450 Asbury Ci	rcle Apt	129		10f. Zip	Code 2068	38			-	en of What Cour ted Sta	•
5-0036	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. de Hylgiene. de other than "natural", or llems 23a or 28a-f show event, the Medical Evandrar must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	Armed For	2 <b>X</b> No		Was Deced f Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: Wh	
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е, маг	1 and 1 ealth 9 m 27 ther to		19a. Informant's Name/Relationshi  Carolin B. Head  20a. Method of Disposition		20b. P	111 Su	Initiary	71112	ige D	r. A	i Route Numbe nnapoli ate	s MD	Town, State, Zip	
altimor	permit. Pages Department of I Important: If ite any injury or o'		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service Li	ecify)	State Ar]	emetery, cren Lingtor 22	natory or ot n Nati . Name and	ona.	r Gew				gton Vii Home PA	-
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	the Hosp hin 24 hou the Fune mpletely fil	Medical	29a. Certifier (Check only one)  2 Medical E	Physician: To the xaminer: On the ba and mann	isis of examina	wledge, death tion and/or inv	estigation,	it the time in my op License	inion, deat	d place, a h occurre	ed at the time, o	date and p	and manner as st place, and due to signed (Month, i	the cause(s)
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1	3D		30. Name and address of person w	PC10	cerred	rich.		ND	20	678	3			
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			1 - For Stete Registrar	ate of Marylan	d / Depa <i>Cei</i>	artment of H	lealth ar Death	nd Mental Hy	giene ()	04	381	35
	Physici	an	Decedent's Name (First, Middle, Last)				<u> </u>	2. Date of De		Year	3. Time of	_
	/Media	al	Bernard E. Bassfo					Novembe	er 12,	2004	2:55	Рм
	Examin	ier	4a. Fecility Name (If not institution, give street Chesapeake Hospice			4b. City, Town, or	thicum			ty of Death e Arui		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	th	9. Birthi	place (State or	Foreign
	Director		220-05-5704 XXM	<sup>2□ F</sup> 86	Yrs.	Months Days	Hours	Sept.	26, 191	8 Ma	ryland	
	fand		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside Cit	y Limits
	Mary a-f sh	tor	Maryland Anne Arund	lel		Anna	polis				1 🔀 Yes	2 🗌 No
	or 284	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen of		intry?	
	sath w	ral	931 Edgewood Road, A		0 40 1		403	.0./0		.S.A.		
(0	riter de	<b>Funeral Director</b>	1 ☐ Never Married 2 🔀 Married 1	/as Decedent Ever in U. med Forces? [XYes 2 ☐ No				n? (Specify Yes or No Puerto Rican, etc.)		ace - Americack, White,	, etc.	
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Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "neturel", or items 23a or 28a-f show or other treumatic event, the Medical Exembrant must be multified at	Be	17. Father's Name (First, Middle, Last) Richard Irving Bassf	ord				Name (First, Middle		.me)		
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altimore,	as 1 au of Hea item		20a. Method of Disposition		lace of Dispo	sition (Name of natory or other place	1	Date	20c. Location			
Ē	Pages ment of I tent: If its jury or o		1 X Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	St.	_	s Cemete		1/16/2004				
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U			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	ns that caused the death use on each line.	n. Do not ente	er the mode of dying	g, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Betw Onset and D	reen
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	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):							-
	xacute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):							
8760	The law requires that the death certificate be exacuted te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai E	d	,	,							
89	rtificat ng phy as th	Medi	IF FEMALE:									
Вох	leath certific attending p	lan/I	23b. Was decedent pregnant 12 months?	yes, outcome of pregna □Live birth 2 □ Fetal	death 3	Ectopic pregnancy				ate of delive	•	ear
0	that the de led by the a detached f	Physiclan/Me	1 ☐ Yes 2 ☐ No 4	□Pregnant at time of de □Unknown	eath 5∟	Other (specify)					,	
s, p	res that igned b be deta	by Pł	Part II. Other significant conditions contribute	ting to death but not resu	ulting in the ur	derlying cause give	n in Part I.	23e. Did t	obacco use cor	stribute to the	he cause of de	ath?
ğ	w require been sig should b							11	Yes 2 No	3 Prob	oably 4 □Ur	ıknown
Record	has be	Completed						24a. Was		prior to coi	psy findings av	vailable use of
		e Col	OF Was case referred to modical	-				1 ☐ Yes	2/No	death?	2100	
Vita	Physician: r this certifica ral director, p	0 8	25. Was case referred to medical examiner?  1 Yes 2 No Hospit	al: 1  Inpatient 2 1	ER/Outpatien	t 3□ DOA Othe	100	ng Home 5 Resid		her (Specif	NOSP	ice
Division of	ng Ph fter th meral	on: T		a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe I			" \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	<u> </u>
Sio	ttendi death. ctor: A / the fu	icatl	2 Accident investigation 3 Suicide 6 Could not be	- Diagrafiaium Atha			res 2□No		Carana and Alice		1 D- 1- M	
<u>&gt;</u>	al or A s after of Dirac	Certification:	4 Homicide determined 28	<ul> <li>e. Place of Injury - At ho building, etc. (Specify</li> </ul>	()	eet, factory, office		28f. Location (: City or Tox		ber or Hura	u Houte Numbi	91,
	To the Hospital or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical (	29a. Certifier (Check only one)	a: To the best of my known the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and p inion, death	place, and due to the occurred at the time,	cause(s) and m date and place,	anner as si and due to	tated. the cause(s)	
	To the To the comp	ž	29b. Signature and title of gertifier	111		29c. License	number		29d. Date signe	ed (Month,	Day, Year)	
			20 James of the Color	WIN THE STATE OF T	0201 (75	y) L4	J JK		1401	. 2,0	WU 7	
			30 Nameland address of person who comple	ted cause of death (Item  32. Figistrar's Signal	900	BESTA	1081	20300 Ar	MAPO	usu	11)214	(0)
	Sta Registr		NOV 1 5 2004		& A	all .						

			1 - For State Registrar	State o	f Maryla		artment of H <i>rtificate of L</i>		Mental Hygie	epe 2004	38136
	Division		1. Decedent's Name (First, Middle, La						2. Date of Death Month		3. Time of Death
	Physici /Medic		Dorothy Ann Bo						November	,	7M
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or			4c. County of [	
			Anne Arundel II 5. Social Security Number 6.3	Medical		rs. last birthday)		napolis   If Under 24 Hr			Arundel
	Funeral Director			1 M 2 <b>X</b> F	68	Yrs.	Months Days	Hours Mir		1936 I	Birthplace (State or Foreign Country)  New Jersev
	D		Usual Residence of Decedent				·				
	arylar show	_	Maryland Anne A	Arundel	10c.	City, Town or Lo		apolis			10d. Inside City Limits  ↑ Yes 2 \ No
	the M 28a-f	ecto	10e. Street and Number	II WIGGE			10f. Zip Code	POILS	100	g. Citizen of Wha	
	with with Ba or	Funeral Director	1708 Nimitz Driv	<i>r</i> e			701. Zip Code	21401	100		S.A.
	death ms 2%	era	11. Marital Status	12. Was Dece		n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		Specify Yes or No-	14. Race - /	American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, The Medical Examinar must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2⊠No ve		if Yes, specify Cuba 1 ☐ Yes 22X No	n, Mexican, Pue Specify:	nto Hican, etc.)	Specify:	White, etc. White
2-0	72 ho natur jical	Completed	15. Decedent's E (Specify only highest gr			(Give	dent's Usual Occupa	turina most of w	orkina 16	6b. Kind of Busin	ess/Industry
7	vithin ne. han *	mpl	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	Social W	)		Cocial (	Correi coc
5	filed v Hygie ther t nt, in		17. Father's Name (First, Middle, Las.	5+			SOCIAL W		ame (First, Middle, Ma		Services
Maryland	d be antal ked o	To Be	Michael McNamar						len Hogan	aldon Comano,	
ary	shoul ind M ind M ind M	F	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street a		Rural Route Number, (	City or Town, Sta	te, Zip Code)
	and 2 latth a latth a lattra		Kathleen Ward/da	aughter			Emerald F		ive Westm	inster,	MD 21158
Baltimore,	jes 1.2 of He of teπ or oth		20a. Method of Disposition  1XXBurial 2 ☐ Cremation 3 [	Removal from	State 208	o. Place of Dispo cemetery, crei	osition (Name of matory or other place	θ)	Date 20	Oc. Location - City	y or Town, State
Ë	t. Pag tment tant:		4 □Donation 5 □ Other (Special	fy)	St	~~ / -	s Cemeter	- '			s, Maryland
Ba	Depar Depar Impor any ir		21. Signatur Funeral Stryd Lice	E,	til	2014	2. Name and Addres 7 Duke of	Glouce	ohn M. Tay ster St. A	lor Fune nnapolis	eral Home s, MD 21401
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that of one cause on e	aused the deach line.	eath. Do not ent	ter the mode of dying	g, such as cardia	ac or respiratory arres	r!	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Hen	norrl	na gic	cerebro	lves	color ac	ciden	Offiser and Death
	/Medical Examiner		rosuming in dealin)	Due to	(or as a cons	sequence of):					
	2 50 10	er	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. — Due to	(or as a cons	equence of):					
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Ö,	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to	(or as a cons	sequence of):					
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9	ding p	/Me	IF FEMALE:	23c. If yes, out	come of ore	onancy				224 Date of	f delbases
Вох	atten atten I for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live b	ointh 2 P	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
Ö	the d by the ached	hysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unkn					120		
ري ح	The law requires that the death certifi sie has been signed by the attending bage 2 should be detached for use as	by P	Part II. Other significant conditions	contributing to d	eath but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribut	te to the cause of death?
ord	w require been sig should b	ted t				-			1 ☐ Yes	2 3 [	Probably 4 Unknown
Records,	e faw ri has be je 2 sh	Completed							24a. Was an autopsy	prior	e autopsy findings available to completion of cause of
		Соп							performe 1 ☐ Yes 2		
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	\c-	eath (Check only one)		
of	Phys this al di	2	1 Yes 2 The	28a, Date	_	ER/Outpatier 28b. Time o		4 🗆 INUISING	Home 5 Resident		Specify)
on	ding Ih. th. After funer	tion	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Mon	th, Day Year		Work	(?Î Yes 2.⊡No	200. 2000. 20 110.	injury coodinou	
Division	for Attendater deat	ertification;	3 Suicide 6 Could not to determine determined	28e. Place	of Injury · A	t home, farm, str	reet, factory, office				r Rural Route Number,
ā	tal or A rs after al Dire ed in by	Cert	- Inditional	buildi	ng, etc. (Spe	ecily)			City or Town,	3(4(6)	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edicai	29a. Certifier Check only one)	miner: On the b	best of my lasis of exam ner stated.	knowledge, deat ination and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occ	e, and due to the cau curred at the time, date	se(s) and manne a and place, and	r as stated. due to the cause(s)
)	To the comp	M	29b. Signature and title of certifier		40		29c. License	number	27	I. Date signed (M	fonth, Day, Year)
			14	completed caus	se of death (I	tem 23a) (Type,	Print) A	1.17	ILL	(-	T.
	Sta	te	31. Date filed (Month, Day, Year)		strar's Si	gnature	e Down	061 1	1501000	160	111.
4	Registr	-	NOV 15	2004	Bour	1296	park				

State of Maryland / Department of Health and Mental Hygiene 00 4 38137 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Arthur Belles Boudman November 14, 2004 1:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1653 Eton Way Crofton Anne Arundel Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours XXM 2 F 89 Yrs. Director 162-05-0879 July 9, Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits item 27 is marked other than "neturel", or items 23a or 28e-1 show other treumatic event. The Medical Examinar must be inclined at Anne Arundel 1 ☐ Yes 2 No Maryland Crofton Director 10e. Street and Number 10f, Zin Code 10g. Citizen of What Country? 1653 Eton Way 21114 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 1941-72 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within; Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "I any injury or other treumatic event, II a Med any injury or other treumatic event, II a Med 2008. Elementary/Secondary (0-12) College (1-4or 5+) Colonel U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Monroe Boudman Adah H. Belles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion L. Boudman/wife 1653 Eton Way Crofton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State McEwensville Cemetery 11/20/2004 McEwensville, PA \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signatur road 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CardioRespiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Disseminated Prostatic Carcinema 3 years Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Malnutrition from cancer 1 Yes 2 No 3 Probably 4 ☑Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2[X No 1 Yes 2X No 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of After t Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D23286 Nov. 14, 2004 of death (Item 23a) (Type, Print) 30. Name and address of person who completed caus 1657 Eton Way Dr. Roy Myers Crofton, Maryland 21114 31. Date filed (Month, Day, Year) istrar's Signature NOV 1 5 2004 Registrar

			1 - State Registrer	State of Maryland		artment of H rtificate of L		Reg.	/	38138
	Physici		1. Decedent's Name <i>(First, Middl</i> e, <i>Las</i> Carl	t) Leo	i.	Bennett		2. Date of Death Month November	Day Year 16, 200	3. Time of Death  3. 2 7 A M
	/Medic Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County of Dea	
		м	427 Furnace S 5. Social Security Number 6. So		ant hirthdoul	Cumb	erland If Under 24 Hrs.	8. Date of Birth	Allega	
	Funeral Director		217-14-4726	M 2□F 79	Yrs.	Months Days	Hours Min.	(Month, Day, Ye 04/27/19	25 Ma	rthplace (State or Foreign Country) ryland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary B-f sh	tor	MD Alleg	any	Cum	berland				1 Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	Country?
	eath w	Funeral	427 Furnace S	12. Was Decedent Ever in U.S	3 13 1		L 502	city Vee or No-	USA	erican Indian
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event. The Mudical Example at must be righted at ance.	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ⊠Yes 2 □ No If Yes, Give Year or Dates: ₩₩ I I		fYes, specify Cuba 1 ☐ Yes 2 ☒ No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	Rican, etc.)	Black, Wh	
21215-0036	72 ho 'natur dicul	eted	15. Decedent's Ed (Specify only highest gra	ucation de com <i>pleted)</i>	(Give	dent's Usual Occupa kind of work done of	luring most of workir	ng 16b	. Kind of Business	s/Industry
12	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	<i>00 NOT us</i> e retired, <sub>-</sub> aborer	)		Natural	Gas
<u>ک</u>	e filed al Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Maid	den Surname)	
<u> </u>	ould b Menta	To	Harry		ipley		Amanda 	<u></u>	Benne	
Maryland	d2sh thand thand ?7Ism traum		19a. Informant's Name/Relationship (7) Clara C. Bennett	• • • • • • • • • • • • • • • • • • • •		-		<i>l Route Number, Cit</i> Cumberlan		Zip Code) 1502
	is 1 and the all item 2		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of natory or other place	! D		Location - City of	
altimore,	Page ment c ent: If		1 🕅 Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specify	Removal from State	stlawn	Mem. Gar	dens 11/1		LaVale,	
Balt	permit. Depart Import any inj		21. Signature of Auneral Service Licen	allend				ams Famil , Cumberl		1 Home, F.A. 21502
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not ente	er the mode of dying	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
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	Examiner			Due to (or as a consequ	ence or):					
	sit ad	Iner	Sequentially list conditions, Teny, to admit to minimulate cause. Enter Underlying Cause (Disease or injury	One to (or as a consequ	anna offi					
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68760,	ificate be executed g physician and as the burial-transit	edical Examiner		d.						
_	ertifica ding ph		IF FEMALE:	23c. If yes, outcome of pregnar						
P.O. Box	res that the death certifigned by the attending igned by the attending be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetel 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other <i>(specify)</i>		))	23d. Date of de Month	Day Year
0	at the	hys	9 🗆 Unknown	9□ Unknown		,				
	Attending Physicien: The law requires that the death certis redeath. sector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a by the funeral director.	þ	Part II. Other significant conditions or Carcinoma of		lting in the ur	nderlying cause give	n in Part I.		o use contribute t 2 □ No 3 □ P	o the cause of death? robably 4 Unknown
Division of Vital Records,	e law requir has been si je 2 should	Completed						24a. Was an autopsy	24b. Were a prior to	utopsy findings available completion of cause of
<u>a</u>	n: The ficate nr. pag		OS Was assessationed to modical			. =		performed 1 □ Yes 2 🖼		s 2□ No
Ē	ysicie is certi directo	To Be	25. Was case referred to medical examiner?  1 ☑ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Othe	26. Place of Death	(Check only one) ne 5 A Residence	6 ∏Other (Spe	ecify)
n O	ng Ph (fter th uneral	L :uo	2 Nanner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe how in		
Sio	death. ctor: A	Certification:	Accident investigation  3 Suicide 6 Could not be		ne farm stre		'es 2 □ No	8f. Location (Street	and Number or R	ural Route Number
2	al or A s after Il Direct	Sertif	4 ☐ Homicide determined	building, etc. (Specify)	110, 141111, 3(16	set, factory, office		City or Town, St		arar rioute realiber,
	To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	edical C	29a. Certifier (Check only one)  1 Certifying Ph	sicien: To the best of my know iner: On the basis of examinati	rledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and place, a inion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)
	Fo the within ?	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29d. I	Date signed (Mont	th, Day, Year)
تُ	3/1UA		1/46.1	1		D	09157	N	ovember	16, 2004
C	nds			completed cause of death (Item						
	Sta	te.	Paul Snow, M. 31. Date filed (Month, Day, Year)	32. Registrar's Signatu			Cumber1an	d, MD 21	502	
	Registr		NOV 1 7 2004	37. Registrar's Signatu		sports				

Please Type or Print in Bla	ack Indelible Ink. Ensure	All Copies Are Legible.
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			1 - State Ragistua END#23a(b)pe	State of M aMD11/16/04.	laryland/ BMW.McCo	Depa Cer	ırtmeni <i>tificate</i>	t of H e <i>of L</i>	ealth an D <i>eath</i>	nd Mental H	ygien Reg. N	. • • •	38139
	Physici	an	Decedent's Name (First, Middle, La	ist)						2. Date of Month	Death	av Year	3. Time of Death
	/Medic	al	HARRY  4a. Facility Name (If not institution, given	o street and number	COH	SN .	Ab Cib.	Tour or	Location of D	NOVEM		2004 c. County of Dea	12:50 P M
	Examin	er	SUBURBAN HOSPITA		,		40. Oily,		THESDA		40	MONTGO	
	Funeral Director		Social Security Number 6.		ge (In yrs. last i	oirthday) Yrs.	If Under Months		If Under 24		Birth Day Year	Q Rir	thplace (State or Foreign puntry)
	pu ,		Usual Residence of Decedent		10c. City, To								Teach
	laryla ahov	'n	10a. State 10b. County		Toc. City, 10								10d. Inside City Limits 1 X Yes 2 □ No
	the N	Director	MARYLAND HOWARD  10e. Street and Number			COL	UMBIA 10f. Zip				10a C	itizen of What Co	
	3a or	Ö	5112 WATCHWOOD	PATH				2104	44	Į			S OF AMERICA
36	be filed within 72 hours after death with the Maryland tial Hyglene. ad other then "naturel", or Items 23e or 28e-f ehow event, the Medical Examinat must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1  Yes 2  If Yes, Give Year or Dates:	7		Vas Deced i Yes, spec		spanic Origin n, Mexican, P Specify:	? (Specify Yes or Puerto Rican, etc.)		14. Race - Ame Black, White Specify:	erican Indian, te, etc.
5-0036	2 hour		15. Decedent's E	ducation		a. Deced	lent's Usua	I Occupa	tion		16b. h	Kind of Business	WHITE
21215	within ene. than "	Completed	(Specify only highest gr Elementary/Secondary (0-12) 1.2	ade completed) Coilege (1-4or	5+)	(Give life. L	kind of wor OO NOT us ESALE	rk done d se retired)	uring most of	f working			FOOD SUPPLIER
d 2	il Hygie othar ant,	BeC	17. Father's Name (First, Middle, Las	")		110 11	DITUE	-		Name (First, Midd			DOLL BILL
/lar	should be filed nd Mental Hygi markad othar imatic evant, I	To B	MAX COHEN							RACHEL MI	SHAN	IYEH	
, Maryland	nd 2 sulth ar 27 is		19a. Informant's Name/Relationship MAX COHEN - SON	(Туре, Print)						or Aural Aoute Num RT, POTON			
Baltimore,	Page nent o ant: K		20a. Method of Disposition 1	□Removal from State	) [	ery, cren	sition (Nam natory or ot EMORIA	ther place		Date 11/10/04		LNEY, M	
Balt	permit. Departr Importe any inju		21. Signature of Euneral Service Lice	nsee		D2 1	NZANS 70 RO	d Address SKY-( OCKV	OLDBE LLLE P	RG MEMORI	AL C	HAPELS,	INC. 20852
	Priysician /Medical Examiner	er	23a. Part. Enter the disease, or con shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or as	s a consequence	(4 e of): ralq	fair	e of dying	e, such as car	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	ledical Examiner	cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a consequenc	e of):							
O. Box	The law requires that the death certifi tie has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		of pregnancy 2  Fetal dea It time of death		Ectopic pre Other (spe					23d. Date of de Month	ivery Day Year
rds, P	quires that n signed b	by	Part II. Other significant conditions	contributing to death	but not resulting	in the ur	derlying ca	ause give	n in Part I.		l tobacco		the cause of death?
Records,		Completed								ре	is an opsy formed?	prior to death?	utopsy findings available completion of cause of
Vita	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	11				-		Death (Check only	one)		
of	this al dil	2	1 Yes 2 No	-	ent 2 ER/	Outpatien Time of	_	_	4 🔲 1401211	ng Home 5 ☐ Re			cify)
	ing After une	tlon	1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, Da		Injury	M	8c. Injury Work 1 □ Y	at ? es 2 □ No	28d. Describ	a now inju	iry occurred	
Division	I or Attanding after death. Diractor: After I in by the fune	Certification	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of Ir	jury - At home, tc. (Specify)	farm, stre				28f. Location	(Street ar	nd Number or Ru e)	ural Route Number,
	To tha Hospital or A within 24 hours after To the Funaral Dirac completely filled in by	edical C	29a. Certifier 1 Cartifying P. (Check only one) 2 Madical Exa	hysician: To the bes minar: On the basis and manner s	of examination a	ge, death and/or inv	occurred a estigation,	at the time in my op	e, date and p inion, death o	place, and due to the	e cause(s e, date an	s) and manner as d place, and due	s stated. to the cause(s)
1	To the within To the comp	Me	29b. Signature and title of certifier	Roque	M		29c.	. License	number	9	29d. Da	ate signed (Mont)	br, Day, Year)
•	12		30. Name and address of person who TARA ROQUE, M.D					OLI O OLI	GEOR	GETOWN RI	, B	ETHESDA	, MD 20817
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 16 2004	32. Regist	rar's Signatur	<i>i</i>	book		, .				

			For State Registrar	State	of Maryla	,	artment of H		Mental Hy	giene Reg. Ne	2001	38140		
	- E.		1. Decedent's Name (First, Midd	e, Last)					2. Date of De	eath		3. Time of Death		
н	Physici /Medio		Oma A.	Clar!	k				Nov	22		3:55 A. M		
	Examin		4a. Facility Name (If not institution	-	umber)		4b. City, Town, or	Location of De	ath	40	. County of Death	1		
			Bayside Care (		T=		Lexingto				t. Mary's			
	Funeral Director		5. Social Security Number 227-09-3614	6. Sex 1 ☐ M 2 🖾 F	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		ay, Year,	9. Birth Con Virg	nplace (State or Foreign untry) inia		
	and and		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or Lo	cation					10d. Inside City Limits		
	Maryl	ō	Virginia Wythe		Wv	theville						1√ Yes 2 No		
	1 the	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Cou	untry?		
	h with	ai D	100 Meadow Run				24382			USA	A			
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dep.ciment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show mortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, I're Medical Examinar must be notified at once.	Funeral	11. Marital Status 1 □ Never Married 2XXMar	Armed	2 📉 No		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or Ne erto Rican, etc.)	0-	14. Race - Amer Black, White	e, etc.		
ဗ္ဗ	ural',	d b	3 Widowed 4 Divorced	Year or			10 163 28 140	зреспу.			Specify: Wh:	rte		
21215-0036	"natu	Completed by	15. Deceder (Specify only highe	it's Education st grade completed	d)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most of w	vorking	16b. k	(ind of Business/l	ndustry		
12	withir ane. than		Elementary/Secondary (0-12)	College	(1-4or 5+)		g Factory W	,		, T	extile			
D 5	filed Hygi other ent, L	0	11 17. Father's Name (First, Middle,	Last)		DCWIII	g ractory w		lame (First, Middle					
lan	ld be ental ked c	To B	Robert Lee Fowler					Olie Ma	e Akers					
Maryland	shou nd M mar	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street			er, City	or Town, State, Z	ip Code)		
ž	alth a	ĺ	Barbara Clark/Daug	hter-in-law		22175	Indian Brid	ge Topal.	California	140	20610			
J.	ss 1 a of He item		20a. Method of Disposition	0.000	1	<ul> <li>Place of Dispo</li> </ul>	sition (Name of natory or other place		Date mber 26,		ocation - City or T	own, State		
Ĕ	Page ment ant: If ury or		1  Burial 2  Cremation  1  Other (5			est End C	emetery		04	Wyth	eville, Vi	rginia		
Baltimore,	permit. Dep. rtr Importa		21. Signature of Funeral Payrice	Licensee	·	Ma	. Name and Address attingley-G eonardtown,	ardiner F	uneral Hom 20650	e, P.	A., P. O.	Box 270,		
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that only one cause or	t caused the di					ırrest,		Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition											
	/Medical Examiner		resulting in death)	Due	o er as a cons	sequence of):—	# 4	1)	()	1		1		
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	ed sit	niner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dust	o (or as a cons	saquence on.								
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8760,	cate be executed physician and the burial-transit	dicai E												
	ificate g phy as the			0.										
Вох	death certific e attending p d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pre		Ectopic pregnancy			ļ	23d. Date of deliv	/ery		
ω.	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2  No	4□Pre	gnant at time o		Other (specify)				Month	Day Year		
P.0	at the	hys	9 ☐ Unknown 9 ☐ Unknown											
ds, F	es ig	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ②Unknown				
Record	> 0 0	Completed							24a. Was			opsy findings available		
ž	0 4 0	mo:								ormed?	death?	ompletion of cause of 2 No		
	ician: Th	BeC	25. Was case referred to medica					26. Place of D	eath (Check only					
of V	00 E	To	O 1 ☐ Yes 2 → No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Re								Residence 6 Other (Specify)			
	ing Witer une	ertification;								d. Describe how injury occurred				
Division	ne Hospital or Attendi 1.24 hours after death. The Funeral Director: A letely filled in by the fi	rtifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Ω	Hospital or 24 hours afte Funeral Dir tely filled in	0							1					
	To the Hospital or At within 24 hours after on To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifyi (Check only 2 Medicel	ng Physician: To t Exeminer: On the and ma	he best of my l basis of exam inner stated.	knowledge, death ination and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	date and	) and manner as a d place, and due t	stated. to the cause(s)		
ı.	To the I within 2 To the I complet	Σ	29b. Signature and title of certific	2012	la la	-11	29c. License	e number	19	29d. Da	te signed (Month,	Day, Year)		
•			30 Name and addition	VIVA!	go W	YVI	Drint)	064	1/	11	1200	7		
				oe, 24035	1			MD 20636	,					
	g Sta	te	31. Date filed (Month, Day Year		Registrar's Sig		A - W -	LID 20036	,					
	Registr	ar	1401	0 2004	MARIAN.	A STORY	103482							

			1 - For State Registrar	State o	of Maryland / D		rtment of H tificate of L		_	giene Reg. No. 0	04	38141
	Physici	an	Decedent's Name (First, Middle		o Comb =				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution		mber)			Location of Death			nty of Death	1750 p <sup>™</sup>
			48219 Pickett  5. Social Security Number	Harbor Co	Ourt 7. Age (In yrs. last birth	dayl	Lexingto	on Park  If Under 24 Hrs.	8. Date of Bir		Mary'	
Ľ	Funeral Director		220-84-9183	1 ☐ M 2 ဩ F		rs.	Months Days	Hours Min.	June 22,	y, Year)	Coun	place (State or Foreign ntry) 11and
	riand ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loc	cation				1	0d. Inside City Limits
	e Many Ba-f sh	Director	Maryland Saint M	larys	Lexi	ngto	on Park					1 □Yes 2 ☑ No
	with th	Dire	10e. Street and Number	<b>a</b> .			10f. Zip Code	2		10g. Citizen o		itry?
	death	Funeral	48219 Pickett Harb		edent Ever in U.S.	13. V	2065. Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No	- 14. F	SA Race - Americ	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. Item 27 Is marked other than "natural", or Itema 23a or 23a-f show other traumatic event. The Madical Examinat must be notified at	by Fu	1 X Never Married 2 Marri 3 Widowed 4 Divorced		2 🔯 No ve		☐ Yes 2 No	Specify:	rnoan, etc.)		Black, White, o cify: White	
2-00	72 hou natura dical E		15. Decedent	's Education	16a. [	(Giva k	ent's Usual Occupa	uring most of work	rina	16b. Kind of	Business/Inc	dustry
21215-0036	filed within Hygiene. other than " ent, the wes	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	life. D	00 NOT use retired, Teacher	, <b>g</b>	9	Pub1	ic Schoo	216
	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M	Be C	17. Father's Name (First, Middle,	_ast)			Todeller	18. Mother's Nam	e (First, Middle,			713
Maryland	should be ind Mental Is marked o	2	John Douglas Combs  19a. Informant's Name/Relationsh	nip (Type, Print)	19b. I	Mailin	g Address (Street a		lizabeth		un Stata Zin	Code
	1 and 2 s Health ar tem 27 is		Dorothy Elizabeth J		her 44	180	Cross Bow ]					
Baltimore,	ages 1 ar nt of Hea t: If item ? r or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation			<i>, ciem</i> ate	atory or other place Heart of Ma	erv Nov	Date vember		n - City or To	
altin	permit. Pages of Popartment of Himportant: If ite any injury or ot once.		*4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I		$\cap$	22.	Name and Addres				on Park,	, Maryland
8	8818		Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650  23a. Partl. Enter the disease, or complications that caused the dead. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate									
R	Pnysician		shock, or heart failure. List	only one cause on a	each line.		e jui					Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a	(or as a consequence of	1	- Jour	sacy i	vourie.	7		
		Jer.	Sequentially list conditions, if any leading to immediate	b. — Due to	or as a consequence of	f)r						
	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequence of	6).						
68760,	ficate be executed physician and is the burial-transit	edical E		d	(or as a consequence or							
	death certificate b attending physic	/Medi	IF FEMALE:	220 H vos ou	teams of grades and							
. Box		Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ∠Yes 2 □ No	1 Live b	tcome of pregnancy birth 2  Fetal death nant at time of death		Ectopic pregnancy Other (specify)				Date of deliver Month	ny Day Year
P.0	The law requires that the de ite has been signed by the a page 2 should be detached		9 Unknown  Part II. Other significant condition	9 Unkn		the un	darhring causa gwa	n in Part I	23a Did to	phacco use co	entribute to th	e cause of death?
Records,	w requires t been signe should be	ed by					adilying oddso givo			′es 2 X/No		ably 4 □Unknown
eco	e law reh has bee le 2 sho	Completed							24a. Was autop			osy findings available inpletion of cause of
_		e Con	25. Was case referred to medical					00 Plan - 1 Paris		2□No	death?	2□ No
of Vital	hysicia nis cart I directi	To Be	25. Was case referred to medical examiner?  1 No									
ono	ding Ph th. After th funeral		27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  2 Accident Investigation Investiga									
Division	r Attenter deatlinector:	Certification:	3 Suicide 6 Could n 4 Homicide determi	et, factory, office 28f. Loc.			cation (Street and Number of Rural Route Number, y or Town, State) 48214					
	spital or ours afte leral Dir filled in		/ \		best of my knowledge,		occurred at the time	(	TUPOUT LF	(1X144	4-14 1-274	EIND
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this cartifics completely filled in by the funeral director.	ledical	(Check only 2\(\) Medical I	Examiner: On the b	asis of examination and/ ner stated.	or inve	astigation, in my op	inion, death occurr	ed at the time, o	tate and place	and due to	the cause(s)
<b>\</b>	To T	Σ	29b. Signature and title of certifier	100 A	0		29c. License	number ME		29d. Date sign		
V	7		30. Name and address of person v	who completed caus	se of death (Item 23a) (T	уре, Р	rint)					
D.			ZABIUUA  31. Date filed (Month, Day, Year)		øgistrar's Signature		111 Pe	nn Stree	t, Balt	imore,	Maryla	and 21201
	Sta Registr		31. Date filed (Month, Day, Year)	2004	Essera 13	10	alle					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 04 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician CHUEH - HUEI TSAI CHEUNG 11:20 P M NOVEMBER \_10 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9001 WANDERING TRAIL DRIVE **POTOMAC** MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Director 226-55-7594 44 JULY 3,1960 TAIWAN Usual Residence of Decedent the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examinations be notified at 1 ☐ Yes 2 🔀 No Director 28a-f MARYLAND MONTGOMERY **POTOMAC** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 20854 9001 WANDERING TRAIL DRIVE U.S.A. 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 X No ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ASIAN þ 3 Widowed 4 Divorced "natural", Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 4 OFFICE MANAGER PHYSICIAN - MEDICAL permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If itam 27 is marked othe any sinjury or other traumatic event RRS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) PO - LIEN TSAI TZU CHU KU 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) DR. NOAH M. CHEUNG - SPOUSE 9001 WANDERING TRAIL DRIVE, POTOMAC, MARYLAND 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) NATIONAL CREMATORY 11/21/2004 FALLS CHURCH, VIRGINIA 21. Signs u es juneral sign 22. Name and Address of Facility NATIONAL FUNERAL HOME 7482 LEE HIGHWAY, FALLS CHURCH, VIRGINIA 22042 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BREAST CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 2 No 1 ☐ Yes of Vital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one Hospital: Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 X Natural 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 53177 NOVEMBER 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850 JOHN M. WALLMARK, M.D.

State Registrar

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year)

NOV 1 8 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) Day Year **Physician** 2004 Η. Coates November 14 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Capitol Heights

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Prince George's 1914 Nova Ave. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🛛 F Yrs. Director 68 May 25, 1936 Wash., DC 579-46-8565 Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Itema 23a or 28e-f show any Injury or other traumatic event, the Medical Examinet must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 ☐ No Maryland Prince George's Capitol Heights Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20743 United States 1914 Nova Ave 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 27 No 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify ģ 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Minister(Pastor) 6 Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles L. Henson Caszita I. Minor 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter T. Coates - Husband 1914 Nova Ave., Capitol Heights, MD 20b. Place of Disposition (Name of cemetery, crematory or other places k 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Maryland National Mem. 11/19/2004 Laurel, MD 21. Signa ure of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 Mewall. 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death 5 Years Immediate Gause (Final disease or condition resulting in death) Breast Cancer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cass (Disease of July) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical be detached for use as the the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2√2 No 24a. Was an was an autopsy performed?
Yes 2 No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 v Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Joseph M. Haggerty MD D32407 November 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph M. Haggerty, M.D. 10605 Concord St., #300 Kensington, MD 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 7 2004

DHMH 17 Rev 1/2001

Registrar

		1 - For State Registrar	State of Maryland / De	partment of Health and Pertificate of Death		ene . N2004 3814			
Physici /Medio		Decedent's Name (First, Middle, Last     ANN GALLOWAY	CRAWFORD		2. Date of Death Month November	3. Time of De			
Examir Funeral	ner	4a. Facility Name (If not institution, give  Bedford Court Num  5. Social Security Number 6. Se	sing Home	4b. City, Town, or Location of De Silve Spring  ay) If Under 1 Year If Under 24 H	rs. 8 Date of Birth	4c. County of Death  Montgomery  9. Birthplace (State or Fr			
Director		577.01.9669  Usual Residence of Decedent  10a. State  10b. County	] M 2 E F 94 Yrs		n. (Month, Day, Y	1910 Maryland			
72 hours after death with the Maryland natural', or itams 23a or 28s-f ehow disul Evat: ill artmust be notified at	rector	Maryland Montgom  10e. Street and Number		rsburg	100	10d. Inside City L 1 ☑ Yes 2 [ p. Citizen of What Country?			
sath with	Funeral Director	8201 Plum Creek l		20882		U.S.A.			
be filed within 72 hours after death with the Marylan ital Hygiene. Ital Hygiene. do othar than "natural; or itams 23a or 28a-f ehow event, the Medical Evar-it arrival by rodified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Amed Forces?  1  Yes 21X No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur     □ Yes 2☒ No Specify:	erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
iene. rthan "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th	e completed) (G College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of w e. DO NOT use retired) Iomemaker	rorking 16	b. Kind of Business/Industry  Own Home			
should be filed nd Mental Hygi markad othar imatic event, I	To Be C	17. Father's Name (First, Middle, Last)  Thomas M. Gallo			ame (First, Middle, Ma Johnston				
perimit. Tages 1 and 2 should be partment of Health and Merit important: If item 27 is marked any injury or other traumetto e once.		Hubert E. Darnell  20a. Method of Disposition 1 图 Burial 2 Cremation 3 中 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	temoval from State Cedar H	sposition (Name of rematory or other place) Hill Cemetery 11/	Date 20 16/2004 Si	sburg, Maryland 20 c. Location - City or Town, State uitland, Maryland INC. ver Spring, MD 20			
hybrician and purish transit t	dicai Examiner	23a. Part1. Enter the disease, or complishook, or beart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	enter the mode of dying, such as carding the mode of dying, such as carding the control of the cardinal dying the cardinal dyin	ac or respiratory arrest	Approximate Interval Between Onset and Deat Color of the			
as been signed by the attending places should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ØNo 9 □ Unknown		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year			
been signed b	by	Part II. Other significant conditions cor	ntributing to death but not resulting in the	e underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown			
ate ha	Completed				24a. Was an autopsy performed				
is certificate he	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	26. Place of Death (Check only one)  spital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)						
After th		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	-	be how injury occurred				
	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)  281. Location (Street and Number or Rural Houte City or Town, State)						
within 24 hours after	Medical	29a. Certifier	sicien: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)			
withir To th comp		29b. Signature and title of certifier  WHOULE WE  30. Name and address of person who co  ANNEW O-FERM  31. Date filed (Month, Day, Year)	)	29c. License number	29d. NN	Date signed (Month, Day, Year) Cueler (3, 200)			
		30 Name and address of person who co	mpleted cause of death (Item 23a) (Typ	e Print)		•			

			1 - For State Registrar	State of I	Marylan		artmen rtificate			and M		Reg. No	A	L.	38145
ě	Physic	ian	Decedent's Name (First, Middle, La     ADRIAN CHER	NIAK							2. Date of Dea	Da		/ear	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, gir		er)		4b. City,	Town, or	Location o		Novembe		3 2 c. County of	004	4:50 P <sup>M</sup>
	ZX		Brighton Garden	s Nursing	Home			thes					Montg		v
	Funeral			Sex 7. 1⊠M 2□F	Age (In yrs. I	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birti (Month, Day	h v. Year	.)	9. Birthpla	ace (State or Foreign
	Director		Usual Residence of Decedent		92						Feb. 16	), l	912 K	ovel	, Ukraine
	arylan show	_	10a. State 10b. County		10c. City	y, Town or Lo	cation							10	d. Inside City Limits
	the M	Directo	Maryland Montgom	ery	Ве	ethesd	a. 10f. Zip	Cada				10- 0			1X Yes 2 No
	h with	al Di	9901 Harrogate F	Road				.0817	,				itizen of Wh $U.S.A.$		ry?
	ems a	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	S. 13. \				gin? (Spe	cify Yes or No- Rican, etc.)		14. Race -	America	
36	72 hours after death with the Maryland natural', or Items 23a or 28e-f show dical Exactivat roust be redified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2	No.		1 🗌 Yes 2		Specify:	, rueno r	noari, etc.)		Specify:	White, e	
Maryland 21215-0036	72 hours "natural",	ted t	15. Decedent's E		s:	16a. Deced	dent's Usua	I Occupa	tion	_		16b K	(ind of Busin		
215	.S - 3	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4c	or 5+)	(Give life. L	kind of wor DO NOT us	k done d e retired)	uring most	of workin	g		(114 01 24011	10331110	25(1)
121	filed with Hygiene. other thar		17. Father's Name (First, Middle, Last	4 Years	5	Eng	ineer	•	40.14.15				tomoti	ive	
and	ould be filed Mental Hyg arked othe atic event,	To Be	Simon Chernial								(First, Middle,		,		
ary	should and Men a marke umatic	F	19a. Informant's Name/Relationship			19b. Mailin	ng Address	(Street a			Horen			ate, Zip C	Code)
	as 1 and 2 should be of Health and Mental litem 27 is marked of other treumatic even		Hanja Cherniak/I	aughter		9901	Harro	gate	Road		thesda				
lore	it of He		20a. Method of Disposition 1 Burial 2 Cremation 3 5	Removal from Sta		lace of Dispo- emetery, cren					ate		ocation - Cit	-	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or oth		<ul> <li>4 □ Donation 5 □ Other (Special</li> <li>21. Signature of Funeral Service Lice</li> </ul>		St.		w's C				/2004 \$	Sout	th Bou	ınd E	Brook, NJ
Ba	Dep Impo		Namen A	Paron	tre	HĨ	NES-R	INAL	DI FU	JNERA	L HOME	IN	IC.	ina	MD 20904
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com shock, or hear failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause.	Pneumon  Due to (or a	nia as a consequ	ence of):			, such as o	cardiac or	respiratory arr	rest,		1	Approximate nterval Between Onset and Death
,0928	death certificate be executed e attending physician and id for use as the buriat-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Arterio	osclero		ardio	vasc	ular	Dise	ase				
.O. Box 6	res that the death certifica signed by the attending pl be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3 🗆	Ectopic pre Other (spe					:	23d. Date o Month	,	ay Year
S	es that gned t	by P	Part II. Other significant conditions of		but not resul	lting in the un	derlying ca	use giver	in Part I.		23e. Did tob	bacco u	ıse contribu	te to the	cause of death?
ord	requi	ted	Dementia, Seni	Te							1 🗆 Ye	es 2[	□No 3[	Probab	ly 4 🛣 Unknown
l Rec	The law ate has b page 2 sl	Completed									24a. Was a autops perform	ned?	prior	r to comp th?	y findings available eletion of cause of
	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	tiont 3 🗆 E	R/Outpatient	3 DOA	Other	-		Check only on				
	Attending Phys or death. ector: After this by the funeral dir	atlon; T	27. Manner of Death  1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D		28b. Time of Injury		c. Injury a	at es 2 $\square$ N	28	e 5 🗌 Reside			Specity)	
	in Dirt	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of I	njury - At hon etc. <i>(Specify)</i>	me, farm, stre	et, factory,	office		28	If. Location (St. City or Town	reet and n. State,	d Number o )	r Rural F	Route Number,
	To the Hospital within 24 hours a "To the Funeral I completely filled	ledical	29a. Certifier 1 ☑ Certifying Ph (Chick only one) 2 ☐ Medical Exam	ysician: To the bes niner: On the basis and manner:	of examination	rledge, death on and/or inv	occurred at estigation, i	t the time n my opi	, date and nion, death	place, an occurred	d due to the call at the time, da	ause(s) ate and	and manne place, and	r as state due to th	ed. e cause(s)
)	vith com	7	29b. Skylature and title a cay for	M	Address Piles		H	License i	number 839	M	A		e signed (M ember		
			30. Name and address of person who Gary E. Raffel,	DO 5411	death (Item 2	23a) (Type, F <b>Cedar</b>	r <sub>int)</sub> Lane	Sui	te #2	202 <b>-</b> A	, Beth	esda	a, MD	2081	4
	Sta Registr	6	31. Date filed (Month, Day, Year) NOV 16 20	32. Regis	trar's Signatu		Ana	. /.	,						

			Unpend Item 23	Ba&27 per mer	(6838 120 Ce	arment of 14 14-04 ta rtificate of	Bealth and Death	Mental Hyo	giene Reg. No. 2 (	004	38146
	Physicia /Medic		Decedent's Neme (First, Middle, L     ELIJAH	ast)	CARTE	:R		2. Date of Dea Month NOVEMB	Day	Year	3. Time of Death 8:25p
زر	Examin		4e Fecility Name (If not institution, gi	ive street end number)			4b. City, Town, or				о.25р
			DOCTORS COMMUNIT				LANHAM		_ 1 .	ICE GI	EORGES
9	Funeral Director		The second secon	Sex 7. Age (In 2 7 2 7	yrs. last birthdey) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Dey Jan. 1	, Year) , 1977	9. Birthp Coun Wes	olace <i>(State or Foreign</i> ntry) t Virgini
	death with the Marylend ms 23a or 28a-f show must be notified at	tor	10a. Stete 10b. County	Georges 10	c. City, Town or Lo Green				· · · · · · · · · · · · · · · · · · ·	1	0d. Inside City Limits 1   Yes 2  No
	ith the M or 28a-f	je	10e. Street end Number			10f. Zip Code		1	l0g. Citizen of	What Coun	itry?
	238 c	alC	9304 Edmonst	on Road #1	03	20	770		U.S.	Α.	
020	oftar Fr	by Funeral Director	11. Marital Status  1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:		Was Decadent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Rad Bla Specif	ca - Americ ck, White,	
21215-0020	is 1 end 2 should be filed within 72 hours of Health and Mentel Hygiene. Item 27 is marked other than "natural, other traumatic event, the Medical Ex	Completed by	15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12) 12th	Education rade completed) College (1-4or 5+)	16e. Decad (Give life. I		pation during most of wor d)	king	16b. Kind of B Natio Archi	nal	lustry
b	be filectel Hyg	Be C	17. Father's Name (First, Middle, Last	t)			18. Mother's Nan	ne (First, Middle, I			
ylaı	should by and Mente marked imatic events	၉	Elijah F. Ca	rter			Delor	es Hick	S		
Maryland	2 sho and is me		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	rel Route Number	r, City or Town,	State, Zip	Code)
	1 end 1 Health em 27 i	1	Delores Humes- 20a. Method of Disposition		1704	Terrap	in Hill				
Baltimore,	Page nent of ury of		1  Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contr	Removal from State	cemetery, crem Parklaw	natory or other plan n Mem P	ark 1	1/28/20		ckvi	lle,MD
Bal	permit. Dapertr imports any inj	4	21. Signetfire of Funeral Service Lice	R. Anouel			ess of Facility Sn Shingto				
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90	tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bDue	to (or es a conseq	uence of):					
x 68760,	= 0° a		resulting in death) Last	Due t	o (or as e consequ	uence of):					
Вох	eath cert attanding	Clar	Dod II Other desidence and detail								
P.O.		5	Part II. Other significant conditions of	contributing to death but not	resulting in the un	iderlying cause giv	en in Part I.		bacco use cor ⊪s 2□No		the cause of death? ably 4 Unknown
Vital Records,	law requires as been sign 2 should be	Completed by						24a. Was ar perform		avai com	re autopsy findings ilable prior to apletion of cause eath?
<u>=</u>	The law ata has b	5						1 <b>2</b> Ye	s 2 No	1,25	Yes 2□ No
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of	hys Fis	ation: 10	1 X Yes 2 No  27. Menner of Death 1 X Naturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Day Yea	2 ER/Outpetient 28b. Time of Injury	28c. Injun World	4 Li Nursing Ho	ome 5 Reside 28d. Describe ho			
Division	ital or Attencins aftar death ai Director: led in by the	Certification:	3 Suicide 6 Could not be determined	e 28e. Pleca of Injury - A building, etc. (Sp	At home, farm, stre	et, factory, office		28f. Location (Str City or Town,	eet and Numbe , State)	er or Runal	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier  (Check only one)  1 Certifying Ph  2 Medical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, death aination and/or inve	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and mai te and place, a	nner as sta ind due to t	ted. the cause(s)
D	To the Comple		29b. Signature and title of certifier  Za Luilla	68 AST		29c. License	ocmE		d. Date signed	-	
			30. Name end eddress of person who o	completed cause of deeth (			ET, BALTI	MORE, MA	RYLAND	2120	1
g	State Registra		31. Dete filed <i>(Month, Day, Year)</i> <b>NOV 2 9</b> 2004	32. Registrer's Si		books					

			For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F			iene g. No. 0 0	L	38147
			Decedent's Name (First, Middle,	Last)				2. Date of Deat Month	h		3. Time of Death
	Physicia /Medic		Julius Fr	anklin	Crandell,	Jr.		Novembe	er 12,20	Year 004	6:00 a M
	Examin		4a. Facility Name (If not institution,		per)	4b. City, Town, o		th	4c. County		
			333 Marlboro R		. Age (In yrs. last birthday)	Lothia If Under 1 Year		8. Date of Birth	Anne		
Н	Funeral Director		5. Social Security Number 218–12–9246	1 M 2 □ F	81 Yrs.	Months Days	Hours Min		Year)	Cour	place (State or Foreign ntry) Vland
	D		Usual Residence of Decedent					Journ 12	71523		
	arylar show	2	10a. State 10b. County		10c. City, Town or L					1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Director	MD Anne A	rundel_		Lothi	an	10	0g. Citizen of W	hat Cour	
	3a or		333 Marlboro Ro	Dec		20711					My.
	death ms 2:	Funeral	11. Marital Status		ent Ever in U.S. 13.	Was Decedent of H		Specify Yes or No-		- Americ	ean Indian,
ထ္ထ	or Ite	y Fu	1 Never Married 2 Marrie	d 1 X Yes 2	No	1 ☐ Yes 2 ☑ No	Specify:	to nican, etc.)	Specify:	k, White,	
Ö	hours lural',	ed by	3 Widowed 4 Divorced	Year or Dat	es:1943-46	dent's Usual Occup			16b. Kind of Bu	1W	nite
2	tiled within 72 hours after death with the Maryland Hygiene. vthar then "natural", or Items 23a or 28a-f show snt, the Medical Examiliat must be multified at	Completed	(Specify only highest	grade completed)	(Give	kind of work done  DO NOT use retired	during most of wo	orking	100. Kind of Bu	311105571110	Justry
212	giene grene ar the	Com	Elementary/Secondary (0-12)	College (1-4	tele	phone PBX	instal]	ler	teleph	one o	company
nd	d fall	Be	17. Father's Name (First, Middle, L				18. Mother's Na	me (First, Middle, M	Maiden Sumam	∍)	
Maryland 21215-0036	should be and Menta markad umatic av	<sup>2</sup>	Julius Frank		randell,	Sr.	Mary	Frances		orela	
<u>a</u>	S 8 8		19a. Informant's Name/Relationsh Thelma T. Crand			. 71					C00e)
ē,	s 1 and f Health itam 27 other tr		20a. Method of Disposition	•	20b. Place of Disp	Marlbord osition (Name of other place)	NOGU, I		20c. Location -		own, State
Ë			1   Burial 2 □ Cremation  Comparison 5 □ Other (Sp	3 □Removal from St ecify)	eib	Cemetery	l l	5-2004	Lothian	n. MT	)
Baltimore,	permit. Page Depertment Important: If any injury or gres.		21. Signature of Funeral Service L	icensee 91		2. Name and Addre					-
	205 2		William	- Am		Rausch Fu				s, MI	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	r as a consequence of):	ter the mode of dyir	/	C or respiratory arre	est,	-	Approximate Interval Between Poset and Death
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O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live bir	nt at time of death 5 (	□Ectopic pregnancy □ Other (specify)	/		23d. Date Mor		ery Day Year
rds, P.	w requires that I been signed by should be deta	by	Part II. Other significant condition	ns contributing to dea	th but not resulting in the t	underlying cause giv	en in Part I.	23e. Did tob	-	ibute to th	ne cause of death?
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Vital	Attending Physician: r death. ector: After this certific. by the funeral director,	o Be	25. Was case referred to medical examiner?	Hospital:		at all pos Oth	0.00	ath (Check only on			
o	g Phys er this eral di		1 ☐ Yes 2 XNo 27. Manner of Death	28a. Date of		of 28c. Injur	y at	Home 5 X Reside 28d. Describe ho			")
lon	utending F death. ctor: After	atlo	1		, <i>Day Year)</i> Injury	M 1 🗆	K? Yes 2 □ No				
Division of	tel or Attenders safter death	Certification:	3 Suicide 6 Could n 4 Homicide determine	286. Place 0	f Injury - At home, farm, st g, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (St. City or Town		er or Rura	l Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funaral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the becaminer: On the base	pest of my knowledge, dea sis of examination and/or in er stated.	th occurred at the tir nvestigation, in my o	ne, date and place pinion, death occ	e, and due to the ca urred at the time, da	ause(s) and mar ate and place, a	nner as st nd due to	ated. the cause(s)
i	To the within 2 To the complete	2	29b. Signature and title of certifier	Cotare		29c, Licens	6364	25	9d. Date signed	(Month,	Day, Year)
1	5+1	\	30. Name and podress of person v	PAPER SE	of death (item 23a) (Type	BUSTGA	TERAS	500 Ann	BLOGA	Mis	1401
	Sta Registi		31. Date filed (Month, Day, Year)	1 5 2004 b	gistry's Signature	Sperke					

			For State Registrar	State of Mar		artment of F			giene 2004	38148
	Physici		Decedent's Name (First, Middle, La Frank Call	st)				2. Date of Dear Month NOV 12	th Day Year	3. Time of Death
	/Medic Examin		4e. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Dea		4c. County of Death	1313
		•	Calvert Memori			Prince F			Calvert	
	Funeral Director		5. Social Security Number 6. S 230 09 7114	ex 7. Age ( 2 F 87	'In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, Day	, Year) Cou	place (State or Foreign ntry)
	σ		Usual Residence of Decedent		On City Town and a			March 7		
	Aaryla f shov	ō	10a. State 10b. County Maryland Calvert		Oc. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-	Irect	10e. Street and Number		Парру	10f. Zip Code	-	1	0g. Citizen of What Cou	
	23a o 23a o ust Le	ralD	950 Golden West W	ay		2065			United St	ates
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "neturel", or items 23a or 28a-f show avent, its Medical Estationer must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ▼Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (s an, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White, Specify:whit	etc.
2-00	r2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	orkina	16b. Kind of Business/In	dustry
121	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	daning most of wo	nkiig	Safeway	
d 2	e filed within al Hygiene. I other than '		17. Father's Name (First, Middle, Last,	<del>-</del>	Paste	urizer	18. Mother's Na	me (First, Middle, I	Lucerne Da  Maiden Sumame)	ıry
ılan	2 should be and Mental Is marked o	To Be	Walter Call				Patty	Oliver		
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (	**	1				r, City or Town, State, Zip	Code)
	1 and Health tem 27		Annie Lee Call - 1  20a. Method of Disposition	wile	20b. Place of Dispo	sition (Name of		Lusby MD	20c, Location - City or To	own, State
OE I	Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cemetery, created Maryland	natory or other place Veterans	Nov 17		heltenham M	
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent; If item 27 lt any injury or other tra ance.		21. Signature of the self-Service Lice			. Name and Addre	ss of Facility		ral Home PA	
	86583		23a. Part1. Enter the disease, or com		440	5 Broomes				20676
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	Sail		ig, such as cardia	ic or respiratory arr	est,	proximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a PNE L	MONIK consequence of):	4				3 weeks
	Examiner	L	Sequentially list conditions,	b						
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury	Due to (or as a	consequence of):					
Ć.	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	CDue to (or as a c	consequence of):					
8760,	cate be ex ohysician the buria	dical		d						
9	the death certificate be executed y the attending physician and tched for use as the burial-transit	/Med	IF FEMALE:	23c. If yes, outcome of	Dreanancy		1.		201 824 115	
Вох	death c	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No	1☐Live birth 2 4☐Pregnant at tir	☐ Fetal death 3☐	Ectopic pregnancy Other (specify)	′		23d. Date of deliver	Day Year
P.O.	t the de by the tached	hysi	9 Unknown	9□ Unknown						
	requires that een signed b nould be deta	by F	COPD, HTN 1	Ontributing to death but			en in Part I.	23e. Did tot	bacco use contribute to the	he cause of death?
Records,	> 0 0	Completed		TINIALLIB	KILLIA CC			24a. Was a		
Rec	e la has	ошо			-			autops perform	ned? death?	psy findings available mpletion of cause of
Vital		Be C	25. Was case referred to medical examiner?				26. Place of De	1 ☐ Yes 2 ath (Check only on		2 2 1 1 1 1
of V	nis dir	은	1 Yes 2 Ho	Hospital: 1 Inpatient			4   Nuising i		ence 6 Other (Specif	y)
on (	ding h	tlon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	Wor		28d. Describe no	ow injury occurred	
Division of	Attending or death. ector: After by the fune	Certification:	3 Suicide 6 Could not b	e One Place of Injury	· At home, farm, str	eet, factory, office		28f. Location (St. City or Town	reet and Number or Rura	al Route Number,
Ö	itel or irs afte rel Dire									
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of e miner: On the basis of e and manner state	xamination and/or in	n occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner as s ate and place, and due to	tated. the cause(s)
	within 2. To the I	Me	29b. Signature and title of certifier	~		29c. License			9d. Date signed (Month,	Day, Year)
•						D36	769		11/13/04	
13	2+1		30. Name and address of person who SCARIA MATHEW				MD	20657		
	Sta		31. Date filed (Month, Day, Year)	5 2004 ► 52	s Signature	hast.		,		
	Registr	ar	NUV I	J ZUU4 > 136	rever so	March				

		•	1 - For State of Maryland / Dep	eartment of Health and ertificate of Death		ene 2004	38149
	Physici	an	1. Decedent's Name (First, Middle, Last)  Thomas Leacester Curtin		2. Date of Death	J	3. Time of Death 2327 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Calvert Memorial Hospital	4b. City, Town, or Location of Deat Prince Frederi	h	4c. County of Death	2321
	Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs. last birthday 217–36–8718 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		8. Date of Birth	9. Birthp	lace (State or Foreign try)
	aryland show	7.	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or L				0d. Inside City Limits 1 ☐ Yes 2又 No
	th the M or 28e-f e notifia	Funeral Director	MD Anne Arundel Lothia  10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	
	ath wi	ral	300 Main Street	20711		USA	
396	72 hours after death with the Maryland 'natural', or items 23a or 286-f show digal Examiner must be notified at	by Fune	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 IXNo Specify:	specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking	6b. Kind of Business/Ind	
121	e filed within al Hygiene. I other then vent, I.e Me		8 17. Father's Name (First, Middle, Last)	Farmer	me (First, Middle, Mi	Family Far	m
ylan	2 should be and Mental Is marked o	To Be	Leonard Thomas Curtin	Kate	M. Perri	9	
Mar	nd 2 sh alth and 27 is m r treum			ling Address (Street and Number or Ri		4	Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	200	20a. Method of Disposition  1 MBurial 2 Cremation 3 Removal from State  20b. Place of Disposition	nosition (Name of ematory or other place)		20711 Oc. Location - City or To Clinton M	
Baltin	permit. F Departme Importar any injur		21. Signature of Funeral Service Licensee	. — — — — — — — — — — — — — — — — — — —	ee Funera	l Home Calv	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Littled Underlying Cause (Disease or injury)	nter the mode of dying, such as cardia	_	st,	Approximate Interval Between Onset and Death
,0928	death certificate be executed e attending physician and nd for use as the burial-transit	edicai Exa	that initiated events resulting in death) Last  Due to (or as a consequence of):				
P.O. Box 6	that the death certific ed by the attending p detached for use as t	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
	es De	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to th	1
Vital Records,	The law ate has b page 2 si	Completed			24a. Was an autopsy perform	prior to cor death?	osy findings available inpletion of cause of
Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Othor	ath (Check only one		
of	ng Phys fter this ineral di	on: To	1 Yes 2 10 1 Inpatient 2 ER/Outpatie  27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Injury Injury	ant 3 DOA 4 Nursing r	10me 5 ☐ Residen 28d. Describe how	ce 6 Other (Specify injury occurred	")
Division	To the Hospitel or Attending Physicaline 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral discompletely filled in by the funeral discompletely filled in by the funeral discomp	Certification:	2	M 1 ☐ Yes 2 ☐ No treet, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
	Hospitel 24 hours a Funerel I etely filled	edicai Ce	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, dead (Check only one)  Certifying Physicien: To the best of my knowledge, dead (Check only one)  and manner stated.	nvestigation, in my opinion, death occu	urred at the time, dat	e and place, and due to	the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifie	29c. License number D-34525	290	1. Date signed (Month,	Day, Year)
l	0+1		30. Name and address of person who completed cause of death (Item 23a) Type  S-T-RAP, M9-4000-Mt (Item 23a) Type	the Road of	220 ; BOI	ne-mo-	-20716
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registre's Signature NOV 1 5 2004	Sparke			

State of Maryland / Department of Health and Mental Hygien 200 L 38150 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12-2004 Year Phyllis M. Cook **Physician** 1240 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 14208 Temple Street Ellerslie Allegany If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3-3-1922 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛱 F 213 12 4535 82 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event. If a Medical Examiner must be rediffied at once. 10b. County WYes 2 No Allegany Completed by Funeral Director Ellerslie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14208 Temple Street 21529 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 200 No If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 <u>Homemaker</u> Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 힏 Henry E. Lowery Emma J. DeVore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14208 Temple Street, Ellerslie, MD Albert E. Cook, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burlal 2 Cremation 3XX Removal from State 4 Denation 5 Dother (Specify) Porter Cemetery 11-15-2004 Hynaman, PA 21. Signature of Funeral Pervice Leensee 22. Name and Address of Facility le Harvey H. Zeigler Funeral Home, Hyndman, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or one cause on each line. Approximate Interval Between Onset and Death MYOCARDIAL INFARCTION Imm siate Cause (Final disease or contillion ACUT Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ∭Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes XXNo 1 ☐ Yes 2 ☐ No certificate 1 Yes Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🏋 No ို 28c. Injury at Work? erel Director: After th 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deat To the Funerel Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12004 Doo 23371 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZAMAL M.D QAMAR ., 625 Kent Avenue, Cumberland, Maryland 21502 31. Date filed (Month, Day, Year) NOV 1 6 2004 32. Registrar's Signature State Registrar

					State of M	aryland			of Health and <i>of Death</i>	d Mental Hy	giene 0	04	38151
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	r deal	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces? 1. 1 Yes 2 □ 1	Ever in U,S	S. 13. V	Vas Deceden	t of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No	- 14. Rac	ce - Americ	
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m	89 E 29		▶:///	Blechek	en Ku	The!	1)	Jarre	ttsvill	Son Fu	neral . land	Home	, P.A.
			23a. Part1. Enter the shock, or heart	disease, or comp	lications that caused	the death.	Do not ente						Approximate Intervel Between
1	Physician		Investigate Occurs (F	to al				. 0					Onset end Death
À	/Medical Examiner		Immediate Cause (F disease or condition resulting in death)	ınaı	a	NP	STAG	e 16	ementis				Years
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P.0	t the c by the tache	hys	raitii. Other signinc	ant conditions co	tabuting to death bi	ut not resul	ang in the un	denying caus	e given in Part I.		onacco use col ∕es 2⊡ No		tha cause of death?
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of Vital Records,	equire een si tould	ted								24a. Was perfo	en autopsy med?	ava	re autopsy findings illeble prior to
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	To the Hospital or Attending Physwithin 2 hours either death.  To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier 1: (Check only 2 one)	Medical Exemi	siclan: To the best oner: On the basis of and manner ste	exeminatio	edge, deeth n end/or inve	occurred et th estigation, in r	e time, date and ple ny opinion, death oc	ce, and due to the courred at the time, or	ause(s) and me date and place, a	nner as sta and due to	ated. the cause(s)
	ro the within ro the	₩ W	29b. Signature and tit	tle of certifier	and maintoi oto			29c. Lic	ense number		29d. Date signed	d (Month, L	Day, Year)
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	12		30 Name end eddres	s of person who co	ompleted cause of de	eath (Item 2	(Typ), F	Print)   1	1 Sto In	6 BUAI :	110		
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	n		Decedent's Name (First, Middle, Last)				2. Date of De		Vaar	3. Time of Death
_	Physici /Medio		Sister Genevieve Dunnigan				Nov.	23, 2004	, Year <del>I</del>	5:45 A. M
Š	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or t			4c. County		
			St. Vincent Care Center		Emmitsh				leric	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Year)	Cou	
	Director		134-40-1892 88 Usual Residence of Decedent				July 2	3 <b>,</b> 1916	Mar	yland
	land ow		10a. State 10b. County 10c. City, Tot	wn or Lo	cation					10d. Inside City Limits
	Many if sh	to	MD Frederick Emmi	tshi	ıro					1⊠Yes 2□No
	r 288	irec	10e. Street and Number	CDD	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	h witi	ai D	335 South Seton Avenue		21727			U.S.	Α.	
	deat	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of His f Yes, specify Cuban	panic Origin? (Sp	pecify Yes or No			can Indian,
9	or He	F	1⊠ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	1		Specify:	rticari, etc.)		k, White,	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Mcdical Examinar must be notified at	d b	3 Widowed 4 Divorced Year or Dates:					Specily	Whi	te
<u>ν</u>	"nat	Completed	(Specify only highest grade completed)	. Dece (Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion ring most of worl	din <b>g</b>	16b. Kind of Bu		•
2121	withir ane. than	g I	Elementary/Secondary (0-12) College (1-4or 5+)		cher			_		ommunity f Charity
2	filed Hygie ther	ပ္သ	17. Father's Name (First, Middle, Last)	ICa		8. Mother's Nam	e (First, Middle	, Maiden Suman		1 Gharity
Maryland	d be antal red o	э Ве	James Conrad Dunnigan				•	cCusker	,	
2	shoul nd Me mark mati	ဥ		b. Mailir	ng Address (Street an				State Zic	Code)
S	nd 2 g		Sister Camilla Harant		South Set					-
<u>6</u>	tem f Hea ftem other		20a. Method of Disposition 20b. Place	of Dispo	sition (Name of natory or other place)		Date	20c. Location -		
ê	Pages ent of ht: If i				PH'S P.H.		;2004	EMMITSE	BURG,	MD. 21727
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licensee	22	. Name and Address	of Facility CK	TIES EI	NERAL HO	י אובי	
ä	Deg m m g		John M. Skiles	2	210 W. MAI					7-0427
			23a. Part . Enter the disease, or complications that aused the death. Do						H	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	<i>t</i> .	· Van				- 17	Onset and Death
	/Medical		resulting in death)  a. Out to (or as a resquence	13():	^	COUNTRY	1		- 1	1 week
	Examiner		a Clarence	d	Demei	itea -	dege	neratu	1	Sylais
	D =	ner	if any, leading to immediate cause. Enter Underlying	of):			0			0
	ecute ind trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last							
90,	oe excian a	ũ	resulting in death) Last Due to (or as a consequence	or):						
38760	icate) be executed physician and s the burial-transit	dicai	d							
_	ding page as	a a	IF FEMALE: 23c. If yes, outcome of pregnancy							
Box	atten for u	ian	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delive nth	ory Day Year
Р. О.	the de	ysic	1  Yes 2 XNo 9 Unknown 9 Unknown	٥.	Cities (specify)					
	The law requires that the death certifi ste has been signed by the atlending page 2 should be detached for use as	by Physician/M	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause given	in Part I.	23e. Did t	obacco use contr	ibute to th	ne cause of death?
g	uires n sign						1 🗆 '	Yes 2⊠No	3 🗌 Prob	ably 4 Unknown
ဂ ပ	w requir been si should	lete					24a. Was	an 24b. V	Vere auto	psy findings available
æ	he la e has age 2	Completed					autor	osy p rmęd? d	rior to cor leath?	npletion of cause of
ta			25. Was case referred to medical			26. Place of Deat			☐ Yes	2 No
>	Physician: r this certificaral director.	o Be	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatien				dence 6 □Othe	ar (Specifi	()
0	g Physer this erthis	ı.	27. Manner of Death 28a. Date of Injury 28b.	Time of				now injury occurre		,
<u>o</u>	ath. r: Aft	atio	1 △Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		s 2 🗆 No				
Division of Vital Records,	r Atte er de recto by th	tific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, f building, etc. (Specify)	arm, str	eet, factory, office		28f. Location (a City or Tox	Street and Number	er or Rura	l Route Number,
ā	tal or A rs after al Director	Certification;	Suitaing, Go. (Spearly)							
	To the Hospital or Attending Phwithin 24 hours after death. To the Funaral Director: After th completely filled in by the funeral		29a. Certifier (Check only (Check only 2 Medical Exeminer: On the basis of examination a	e, death	occurred at the time	, date and place,	and due to the	cause(s) and mai	nner as st	ated.
	the I	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination a and manner stated.							
	To Cor	-	29b. Signature and title of certifier.	11	29c. License r	187A	7	29d. Date signed		
,	,		- January			1010	J	NOVEMBE	R 23	, 2004
	1		30. Name and address of person who completed cause of death (Item 23a) ALAN CARROLL, M.D., 310 S. SETON		,	TIDC NO	21707			
	Sta	te	31. Date filed (Month, Day, Year) 32, Registrar's Signature	AVE	· · EMMITSB	URG, MD.	Z1/2/			
	Registr		DEC 0 2 2004 Same S	9	hone del					

	oh Adam 1 1404 Am Allegin (=	.=~	IN HA 19 B Please			Оера		lealth and N		gien	PONL	38153
			Decedent's Name (First, Middle, L.)	ast)			inoute of	Douth	2. Date of D			3. Time of Death
	Physici /Medio		JOSEPH ADAM 1	DAVIS					Month Novemb		17, 2004	1:55 P M
	Examir		4a. Facility Name (If not institution, ga		er)		4b. City, Town, o	r Location of Death	<u> </u>		c. County of Dea	
			The Memorial Ho	- Ann			Cumber				Allega	
	Funeral Director		5. Social Security Number 213–06–2153  Usual Residence of Decedent	Sex 7 14 M 2 □ F	Age (In yrs. last bir 20	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D MAY 2.	2,19	9. Bi	rthplace (State or Foreign country) RYLAND
	yland now		10a. State 10b. County		10c. City, Tow	n or Lo	cation				· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
	a-fst	ctor	MD ALLEC	SANY	CUMBE	RLA	ND					1X Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code			10g. C	Citizen of What C	ountry?
	ath w	rail	734 BAKER STREE				21502				U.S.A.	
	ter de item	une	11. Marital Status   ★Never Married 2 Married	12. Was Decede Armed Force 1  Yes 2	s?	13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi	
036	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Date:		1	☐ Yes 2X No	Specify:			Specify:	WHITE
-0	72 ho	ted	15. Decedent's I (Specify only highest g	Education	16a.	. Deced	ent's Usual Occup	pation		16b.	Kind of Business	s/Industry
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I fleat that and Mental Hygiene. On thems 23a or 28a-f show other treumatic event, the Medical Examination rolling at	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)		ORER	during most of work d)	ung		RETAIL	
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las					18. Mother's Nam			•	
<u> </u>	nould Men narke	<sup>L</sup>	LLOYD WAGNER -DV						KATHLE			
<u>8</u>			19a. Informant's Name/Relationship					and Number or Rui				
	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tre		LLOYD W. DAVIS  20a. Method of Disposition	/ DATHER	20b. Place of	Dispos	sition (Name of	STREET, C	UMBERLA Date	_	MD 215 Location - City or	
Ö	Pages net of l int; if its		1 Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		cemeter	ry, crem	atory or other plac	DENS 11/2	0/2004		CUMBERLA	
Baltimore.	artme ortan injur		21. Signatura/of Funeral Service Lice		red I Dri	22				_		MD, MD
ä	permit. Departimport any inj		Mond D.	Year how	1ch)		UPCHURCH 202 GREE	ss of Facility I FUNERAL ENE STREE	HOME,	P.A	· MD MD	21502
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caus	sed the death. Do	not ente	or the mode of dyin	ng, such as cardiac	or respiratory	arrest,	מויו למואד	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	as a consequence	d of):	Cordio	myo	puth	4		Onset and Death
- 1		<u>-</u>	Sequentially list conditions, if any leading to immediate	b	as a consaguence	offic					117.1	
	scuted ind transit	aminer	Cause (Disease or injury									
G.	execu in and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or a	as a consequence	of):						
)9/	te be ysicia e bur	cai		d								
89	rtifica ng phy as th	ledi	IF FEMALE:									
P.O. Box 68760.	the Hospitel or Attending Physicien: The law requires that the death certificate be extended to the fours after death certificate be extended to the attending physician and the Funerel Director: After this certificate has been signed by the attending physician and netely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No		2 Fetal death at time of death		Ectopic pregnancy Other (specify)	′			23d. Date of de Month	livery Day Year
۵	es that to igned by be detac	y Ph	Part II. Other significant conditions	contributing to death	but not resulting in	n the un	derlying cause give	en in Part I.	23e. Did	tobacco	use contribute to	o the cause of death?
rds	quires n sigr	d by	Morhid	Ohesi	ty				1 🗆	Yes 2	No 3□P	robably 4 Unknown
0	s been sign	Completed							24a. Was		24b. Were at	utopsy findings available
Be	The lav	шо								ormed?	death?	utopsy findings available completion of cause of
ta	iclen: Th certificate rector, pag	Be C	25. Was case referred to medical					26. Place of Deat		2□ N one)	Yes	2 □ No
>	ysiclen: nis certifica director,	To E	examiner? 1 🎇 Yes 2 🗌 No	Hospital: 1 ☐ Inpa	itient 2/2 ER/Ou	itpatient	3□ DOA Oth	or			6 ☐Other (Spe	ecify)
0	ding Phy h. After thi funeral	:uc	27. Mann of Death  Natural 5 ☐ Pending	28a. Date of Ir (Month, L	njury 28b. T Day Year) I	Time of	28c. Injun Work	y at k?	28d. Describe	how inj	ury occurred	
<u>0</u>	ttendii death. stor: Ai r the fu	catic	2 Accident investigation	on		,,		Yes 2 □ No				
Division of Vital Records.	tel or Attend is after death el Director: /	Certification;	3 Suicide 6 Could not 4 Homicide determine	28e. Place of I building,	Injury - At home, fa etc. (Specify)	rm, stre	et, factory, office		28f. Location ( City or To	Street a wn, Stai	and Number or Ri te)	ural Route Number,
	To the Hospitei of within 24 hours all To the Funerei Dicompletely filled in	Medical	29a. Certifier (Check only 27 Medical Exa	hysician: To the beaminer: On the basis and manner	of examination and	death dor inv	occurred at the tin estigation, in my of	ne, date and place, pinion, death occur	and due to the ed at the time,	cause(:	s) and manner as nd place, and due	s stated. e to the cause(s)
	To the Within To the compl	Me	29b. Signature and title of certifier				29c. License	e number		29d. D	ate signed (Mont	h, Day, Year)
			Y X lork	elle			0.0	C.M.E.		Nov	ember 18	3. 2004
_	2		30. Na d address of person who	completed cause of	death (Item 23a) (		Print)	reet, Bal	timore			
	Sta		31. Date filed (Month, Day, Year)	32. Regis	strar's Signature				CHICLE	, rid	TATORIA A	C1401
	Registr	ar	NOV 2 2	2004   5	ener	9	Spark	41				

State of Maryland / Department of Health and Mental Hygien 004 38154 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 14,2004 10:20 PM Catalina Carnero De Castro /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Hospital of PG County Lanham Prince George's 8. Date of Birth 9. Birthplace (State or Foreign Month, Bay Year) 1935 Country Philippines 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X 69 213 37 2209 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Prince George's Maryland Temple Hills 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4405 Hargrove Road 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2771No If Yes, Give<sup>X</sup> A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo þ 3₩Widowed 4 Divorced Filipino 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other then any injury or other treamers. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Feliciano Carnero Urbarna DeMesa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Orlando De Castro 4405 Hargrove Road, Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Dongapo Memorial Park 11/20/04 Olongapo City, 21. Signatyre of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 011 MO 1340 Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY FORMA rnysician 48 HOURS /Medical Due to (or as a consequence of): Examiner ADVANCED DECOMPESATED CIRRHOSIS OF LIVER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit INFLAMMATION OF LIVER AUID/MMUNE resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical EEDING ESOPHAGEAL VARICES 10 MONAB IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 Yes No 9 Unknown 4☐Pregnant at time of death Month Dav Year 5 🗌 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEVERE COAGULOPATIM IMPERITENSION 1 Yes 2 No 3 Probably 4 Unknown THOMBOCY TOPENIA CORONARY ARTERY DISEASS, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Vas 2 No ANEMIA, RENAL INSUFFICIENCY 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46834 lopen 30. Name and address of person will completed cause of death (Item 23a) (Type, Print) GREENBELF, MO MARY RUNT LOPEZ, MD 7525 GREENWAM CENTER DRIVE 31. Date filed (Month, Day, Year) Registrar's Signature NOV 1 7 2004 Registrar

			For State Registrar	State of	Maryland / Do	epartment of I	Health ar <i>Death</i>	nd Menta	Hygier	ne2004	38155
	Physici		1. Decedent's Name (First, Middle, L					Mor	e of Death	ay Year	3. Time of Death
	/Medic Examir		Pauline Elizabe  4a. Facility Name (If not institution, g		per)	4b. City, Town, o	or Location of		**	4c. County of Death	4 17170
-			17 Maxwe11 Lane 5. Social Security Number 6.	. Sex 7.	Age (In yrs. last birth	North E		4 Hrs.   8 Date	of Birth	Cecil O Birth	place (State or Foreign
ı	Funeral Director		235 26 6378	1□M 2\ F	81 Y	Months Days	Hours	Min. (Moi	nth, Day, Yea	922 West	ntry)
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					I Od. Inside City Limits
	Mary a-f ehe	tor	Maryland Cecil		North Ea	st					1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. 0	Citizen of What Cour	ntry?
	s 23e	eral	644 Bailiff Roa	d 12. Was Decede	net Ever in U.S.	21901	F	-0.40		ted State	
036	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other then "neturel", or Items 23e or 28a-f ehow raumatic event, Ira Madical Examiner must be nullified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Force	es? <b>X</b> No	13. Was Decedent of H If Yes, specify Cub	an, Mexican, I Specify:	n? (Specify Yes Puerto Rican, e	s or No- itc.)	14. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	72 hou	eted	15. Decedent's (Specify only highest of	Education	(0	ecedent's Usual Occup Give kind of work done	during most o	of working	16b.	Kind of Business/In	
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	ife. DO NOT use retire	d)				
1 2 2	illed Hygid other	e Co	17. Father's Name (First, Middle, La.	st)	Mea	t Departme		s Name (First, I		ocery Sto	re
aryland	Menta Menta arked atic ev	To B	Horace Boggs					Lakie C			
Mar	70 10		19a. Informant's Name/Relationship Dollie Isaacs/Da			Mailing Address (Street					
re,	permit. Pages 1 and 2 Department of Health Importent: If item 27 I any injury or other tra once.		20a. Method of Disposition		20b, Place of D	Cherry Streetsposition (Name of	1	Date		y Land 21 Location - City or To	901 own, State
altimore,	Pages ment of I ent: If it ury or o		1 XBurial 2 ☐ Cremation 3  1 4 ☐ Donation 5 ☐ Other (Spec	□Removal from Sta	North E	crematory or other pla ast Method: Cemetery	ist No	ovember 2004	22 Nor	th East,M	arvland
Balt	permit. Departn Importe any inju		21. Signature F era Se e Lio	19/		22. Name and Addre		Crouch 1	Funera	1 Home	
	40360	-	23a. Part1. Enter the disease, or co	Molications that cau	sed the death. Do no					East,Mary	1and 21901 Approximate
b	Pnysician		Immediate Cause (Final	y one cause on eac	h line.						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or	as a consequence of)	vascula	race	civery			elur 5
	Examiner	-	Sequentially list conditions,	b. — Due to /or	as a consequence of)						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D 46 (01	as a consequence or)						
o,	ө өхөс ian an urial-tr		resulting in death) Last	Due to (or	as a consequence of)						
8760	death certificate be executed e attending physician and nd for use as the burral-transit	dlcal		d.			_		_		
ox 6	eath certific attending p for use as	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of delive	·rv
m	death	sicla	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		n 2 ☐ Fetal death It at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	/				Day Year
о. О	that the de ed by the detached	Physic	9 ∐Unknowň N Part II. Dther significant conditions			20 Hadarking agus an	on in Bod I	220	Did tobasso	use contribute to th	o course of death?
Records,	The law requires that the le has been signed by th vage 2 should be detache	ted by			Trout not resulting in the	is underlying cause give	on in raiti.			2 No 3 Prob	
Š	has by	ompleted						24a	. Was an autopsy performed?	24b. Were autor prior to con death?	osy findings available inpletion of cause of
Vital		e Co	25. Was case referred to medical				OF Blace of	1 Death (Check	Yes 22N		2□ No
ot VI	≥ .g o	To B	examiner? 1 ☐ Yes 2 🜠 No	Hospital: 1  Inpa	atient 2 ER/Outpa	atient 3 DOA Oth				6 Other (Specify	Grand daughte
o uc	iding Ph th. : After th : funeral	ion:	27. Manner of Death  1 Natural 5 Pending		njury 28b. Tim Day Year) Inju	ry Wor	k?		cribe how inju	ury occurred	Louse
DIVISION	deal deal ctor / the	ertification:	2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place of	Injury - At home, farm		Yes 2 □ No	28f. Loca	ition (Street a	and Number or Rural	Route Number.
ā	rs afte	O	4 Homicide determine	building,	, etc. (Specify)			City	or Town, Stai	te)	
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	edical	29a. Certifier (Check only one)  1 Certifying F 2 Medical Example 1	Physician: To the beaminer: On the basis aminer and manner	s of examination and/o	leath occurred at the tir or investigation, in my o	ne, date and p pinion, death	place, and due to occurred at the	to the cause(s time, date an	s) and manner as stand place, and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1.		29c. Licens	e number		29d. Da	ate signed (Month, L	Day, Year)
	,		30 Name and attended to	Roy, Mp	of death (harmon )	V/5	5/4		N.	1 cm by	18,2004
	c		30. Name and address of person who	) Sha son	n death (Item 23a) (Ty	ern Che	sayeaks	Hunis	e 12/	lton -	ם ז
	Sta Registr		31. Date filed (Month, Day, Year)	UU4 32. Regi	istrar's Signature	pe, Print)	/	110)//		,	7

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U 0 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 20, 2004 **Physician** ANGIE CHARIOT DYE 4:45 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** ALLEGANY ST VINCENT de PAUL NURSING CENTER FROSTBURG If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 😿 F 87 220-52-7662 Director April 02, 1917 Barton Usual Residence of Decedent it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hygiene. riant: if item 27 is marked othar than "natural", or itams 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or itams 23a or 28a-1 show other traumatic event, the Madical Expriment or ust be notified at Frostburg Maryland Allegany 1 XYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21532 USA 48 Tarn Terrace Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 WNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo White Specify. þ 3 Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 2 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Bittinger Christopher Columbus Broadwater 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bill Dye-son 10137 Coal Bank Drive, Frostburg,, Maryland 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 Burial 2 Cremation 3 Removal from State ortant: If i Moscow Mills, Maryland permit. Page Department Important: It Mt. View Cemetery 23, 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home 3 East Main St., Lonaconing, Md. 21539 23a. P. rt1. Enter the disease, or com-hock, or heart failure. List only or complications that caused the death Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leaving to innite class cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 menths? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknow been signed by the should be detach-Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ar this certificate has by 24a Was an 2 No 1 ☐ Yes 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be . Place of Death (Check only one) 2 1 Tes No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at, Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Funaral Diractor: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) I in by 1 4 Homicide 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Kim Eun 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiege, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11 2004 NOV 3:00 DANIELLE LAFRANCE FELTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY 8. Date of Birth (Month, Day, Nov. 5, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 6 <sup>Year)</sup> 2004 Months Hours Min. 1 □ M 2 🕅 F Director Bethesda, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23e or 28e-f show other treumatic event, the Madical Examiner must be notified at 1 XYes 2 ☐ No Directo VA Stafford Stafford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3606 Aquia Drive 22554 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status e filed within 72 hours after de Il Hygiene. Other than \*natural', or Item Black, White, etc. Yes 2X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black ģ 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygient Importent: If item 27 is marked other the any injury or other treumatic Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carl Felton Nicole Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Felton/ Father 3606 Aquia Drive Stafford, VA 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mullins & Thompson
Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 11/16/2004 Stafford, VA ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Juneral Service Licens 16000 Annapolis Road Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EXTREME PREMATURITY Pnysician /Medical Due to (or as a consequence of): **Examiner** RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Recdfds, P.O. Box 68760. the attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **X**No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Certification: After 1 XNaturat 2 ☐ Accident 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature nd title of certifie 29c. License number 01051105A (IN) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER AGNES SIEROCKA MAJ MC USA BETHESDA MD 20889-5600 32. Redistrar's Signature State NOV 15 2004 Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Physici		CONRAD	LESLIE							Month NOVEMBE	Day	Year 2004		<b>W</b> U
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Baltimore,	permit. Pag Department Important: I any Injury o	- 1	21. Signature of Fune	ral Service Licens	Loche	nch		2. Name and Ad UPCHURC 202 GRE	Ή	FUNERAL	HOME, P	.A. RLAND,	MD 2	21502	
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6	T will will be to the total of		30 Hame and address	of person who co	1	eath (Item 2	3a) (Type,		TR	REET, BAI	LTIMORE,	MARYL	AND 2	1201	
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygien 38159 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Freeman Charles November 17, 2004 11:44 A<sup>M</sup> /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 36820 Oakley Drive Bushwood St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Yrs 53 Director March 10,1951 Washington, DC 177-60-9034 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h Count 10d. Inside City Limits "natural", or Itams 23a or 28a-f shovidical Examinational Decontilled at 1 ☐ Yes 2X No Director St. Mary's Bushwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene. Int: If Itam 27 Is markad other then "natural, or Itams 23s or 2 20618 United States 36820 Oakley Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic evant, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harvey H. Freeman Erma E. Walker 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a ltam 27 l 36820 Oakley Drive Bushwood, Maryland 20618 (FATHER) Harvey H. Freeman Nov. 24, 2004 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If It any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crematory Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licenses MO1095 22955 Hollywood Rd. Leonardtown, Maryland 20650 David A. Goff 23a. Part1. Enter the disease, or comshock, or heart failure. List only Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Diffo (or as a consequence of): /Medical Examiner Sequentially list conditions, Due to for as a considuence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physiclan/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day ō Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 22 es 2 2 No 24a. Was an page 2 has autopsy performed? 1 Yes certificate 2□No Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Y Other (Specify) STENE Hospital: 2 1**∑** Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1. Natural death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by after 4 Homicide within 24 hours aft To tha Funaral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

111 Penn Street, Baltimore, Maryland 21201 HE ODERE Mikung Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrer	State of	Maryland		artmen rtificate				lental Hy	giene Reg. No.	004	381	60
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		4	CIVISTA MEDI						A,			1	HARLES		
	Funeral Director		5. Social Security Number  213-44-4128  Usual Residence of Decedent	6. Sex 1 □ M 2 X F	. Age (In yrs. Ia	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi (Month, Di Jan. 5	nn ay, Yea <i>r)</i> , 194(	Co.	nplace (State or untry) ginia	Foreign
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Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medica examiner?		/			0.1		e of Death	(Check only	оле)			
of	Physicien: this certificated rail director, it	은	1 Yes 2 No			R/Outpatier		1	4 🗀 NI				Other (Spec	ity)	
n	ding P. h. After funera	On:	27. Manner of Death 1 ■ Natural 5 □ Pendir	ig .	Day Year)	28b. Time o Injury		Bc. Injury Work			28d. Describe	how injury	occurred		
Division	Attending r death. sctor: After by the fune	Certification;	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not bo			М		'es 2 🗌		004 1	· C44	11	10	
≥	or At after of Direction by	i i	4 Homicide determ	ined 286. Place o	f Injury - At hor g, etc. <i>(Specify)</i>	me, farm, sti )	eet, factory	, office			City or To	wn, State)	Number or Ru	ral Route Numb	Θ <i>Γ</i> ,
	urs a														
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical		ng Physicien: To the b Exeminer: On the bas and manne	is of examinati										
	o thin o the o the o the o the o the o the	₹	29b. Signature and title of certifie		14	nise.	29c	License	number	-		29d. Date	signed (Manth	, Day, Year)	
	D		A Oule	15 Vida mi	N A	Gior		NI	1908	2/		111	24/04	5	
7	SN		30. Name and address of person	who completed cause	of death (Item	23a) (Type	Print)	TT	100			11/2	1/07		
	/		RANTON DEL DE	CARLONA	701 E	Char	les S	t. 1	aPl	da	MD 20	2641	,		
	Sta	ate	31. Date filed (Month, Day, Year,	32. Reg	gistrar's Signati	ure	A	1		-, 50		J V V Y			
	Regist		MOV	Z 9 2004	Magaers	A.R.	6000	1							

State of Maryland / Department of Health and Mental Hygiene 004

			1 - For State Registrar	State of Ma	aryland / L	Depail Cert	rtment of F rificate of I	lealth and M Death		eg. No.	004	38161
	Physici /Medic		1. Decedent's Name <i>(First, Middle, La</i> Betty	Jane	F	razi	er		2. Date of Dea Month 11/16/		Year	3. Time of Death 4:05 P M
į	Examin		4a. Fecility Name (If not institution, giv				4b. City, Town, or	r Location of Death		4c. C	County of Death	<u> </u>
		١,		General Ho			Cheve If Under 1 Year	erly If Under 24 Hrs.			rince Ge	
	Funeral Director		5. Social Security Number 6. S 219–48–3028		o (In yrs. last bir 52	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 03/27/	1952	9. Birthpl Coun. Wash	lace (State or Foreign try) nington D(
	yland		10a. State 10b. County		10c. City, Town	n or Loca	ation				10	0d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rmust be notified at	ctor	Maryland Prince G	eorge's	Ft. W	V ash	ington					1 ☐ Yes X2 X0 XNo
	or 28	Director	10e. Street and Number				10f. Zip Code	<b>-</b>	1	_	en of What Coun	try?
	eath v	Funerai	11101 Navigators	12. Was Decedent 8	Ever in 11 C	12 14		)744	a # . V = a N =		USA 4. Race - America	an Indian
0030	be filed within 72 hours after death with the Marylan ital Hyglene. Id other than "natural", or liems 23a or 28a-1 show event. The Mazikal Examinar must be notified at	by	11. Marital Status  X⅓ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 1  If Yes, Give  Year or Dates:			as Decedent of H Yes, specify Cuba □ Yes 2 ⊠ XNo	ispanic Origin? (Spe an, Mexican, Puerto I Specify:	Rican, etc.)		Black, White, e	
ם כ	72 ho natur	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a.	Decede (Give ki	nt's Usual Occupi ind of work done	ation during most of workin	ng	16b. Kind	d of Business/Ind	ustry
7	e filed within at Hygiene. other than vent, me Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			1)			Disable	h.
2	Hygie Hygie other		17. Father's Name (First, Middle, Last,	)		שונע	sabled	18. Mother's Name	(First, Middle, I	Maiden S		
yland		To Be	Walter Kenneth	Frazier Sı	£ .			Edith M	arie Shi	рр	,	
ary	ges 1 and 2 should be t of Health and Mental If item 27 is marked or or other traumatic ev		19a. Informant's Name/Relationship (					and Number or Rura				
, E	of Health itam 27 other tr		Edith Marie Fraz	ier / Mothe				ors Court				
	Pages 1 nent of F int: If its iry or ot		20a. Method of Disposition  1XXBurial 2 Cremation 3 C				tion (Name of atory or other place	Cem. 11/2			ation - City or Tov	
Бантто	그 든 문 중		*4 □Donation 5 □ Other (Specify 21. Signature Funeral Service Licer	1	Jot. Ma	20	Name and Address	o of Facility			nton, Ma	
Ď	Depa Impo any ir		JANG. K.	also b		61	.60 Oxon	George P. Hill Road	Kalas Fi	unera Hill.	al Home P	A d 20745
			23a. Parts. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do r	not enter	the mode of dyin	g, such as cardiac or	respiratory arre	est,		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	a consequence	voh of):	c Cardo	covescul	an Bi	rea	se c	Onset and Death
iii d	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of	of):						
	ificate be executed g physician and as the burial-transit	хаш	that initiated events resulting in death) Last	c. Due to (or as a	a consequence (	of);						
00/00	e be e rsiciar e buria		(	d								
0	= 00 6	<b>ledicai</b>		J								
.O. DOX	The law requires that the death certif ite has been signed by the attending bage 2 should be detached for use at	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel death		ctopic pregnancy Other (specify)			230	d. Date of deliver Month I	y Day Year
cords, r	uires that signed b	Completed by PI	Part II. Other significant conditions of		it not resulting in	the und	derlying cause give	en in Part t.		acco use		e cause of death?
2	s beer 2 shou	piete	Ranul Fails	re /los	pre	un	String	<i>\\</i>	24a. Was ar		24b. Were autop	sy findings available
ř		Com	monstel resta	daton					autops perform	red?	prior to com death? 1 🗌 Yes 2	pletion of cause of
II a	cian: ertific ector.	Be (	25. Was case referred to medical examiner?					26. Place of Death				
5	Physi this c	10	1 Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatier 28a. Date of Injur			3 DOA Othe	4 Li Nursing Hom				
5	ding th. After funer	tion	1. Natural 5 Pending 2 Accident investigation	(Month, Day		ime of	28c. Injury Work	rat (? Yes 2 □ No	8d. Describe ho	w injury c	occurred	
NISION	f or Attendi after death. Director: A J in by the fu	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Inju	ry - At home, far	rm, stree			8f. Location (Str	eet and h	Number or Rural	Route Number,
5	ital or rs afte ral Dir led in	Cert	4   Homicide	building, etc	. (Ѕрөспу)				City or Town	, State)		
	To the Hospital or Attending Physician: white 24 hours after deals after deals To the Funaral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifying Ph (Check only one)  2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination and	, death o d/or inve	occurred at the tim stigation, in my op	ne, date and place, as pinion, death occurre	nd due to the ca d at the time, da	use(s) an ite and pl	nd manner as sta lace, and due to t	ted. the cause(s)
	To t with To t	Σ	29b. Signature and title of certifier	e . Ce	1 has	2	29c. License	number / 5 2			signed (Month, D	lay, Year)  1) Zopy
K	2(2)		30. Name and address of person who					sville, Mar	,	12/7 E		
É	Sta	te	Paul DeVore M 31. Date filed (Month, Day, Year)	A. Registra	ueensbur r's Signature	y K	u. Hyatt	svine, Har	учана д	20781	L	
	Registr		NOV 1 8 2004	Here	1 19	how						

DHMH 17 Rev 1/2001

FRANCIS

7. Age (In yrs. lest birthday)

Certificate of Death

4b. City, Town, or Location of Death

CLINTON

If Under 1 Year If Under 24 Hrs.

1 Decedent's Name (First, Middle, Last)

4a Fecility Name (If not institution, give street end number)

SOUTHERN MARYLAND HOSPITAL

PATRICIA

5. Social Security Number

Physician

/Medical

Examiner

**Funeral** 

Reg. No. 2004 2. Dete of Death November 14 2004 10:50 AM 4c. County of Deeth PRINCE GEORGE'S Birthplace (State or Foreign Country) 1934 Brooklyn NewYork 10d. Inside City Limits 1 ☑ Yes 2 ☐ No 10g. Citizen of What Country? U.S.A. Race - American Indian, Black, White, etc. Specify: Black. 16b. Kind of Business/Industry Government 20c. Location - City or Town, State 11/17/04 Riverdale, Maryland J. B. Jenkins Funeral Home Onset and Death 23b. Did tobacco use contribute to the cause of death? 4) Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? 1 🗆 Yes

28f. Location (Street and Number or Rural Route Number, City or Town, Stefe)

29d. Date signed (Month, Day, Year)

death. after death

24 hours a Funeral C within 2 To the 10

State Registrar

Medical

31. Date filed (Month, Day, Year) 8 2004

6 Could not be determined

nound

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Suicide

29a. Certifiei (Check only one)

4 Homicide

29b. Signature and title of certifier

Sisom Osia M.D.



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

**ORIGINAL** 

Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29c. License number

6192 Oxonhill Road # 500 Oxonhill, Maryland 20745

D48158

DHMH 16 Rev 6/95

			For State Registrer		State o	f Maryla	nd / Depa	artment of H rtificate of	lealth a	and M		giene Reg. No.	004	38163
1	Dharisi		1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici: /Medic		Sabrina	G.		Fau1kne	r				11	07	04	12:30 P M
	Examin		4a. Facility Name (If not institution	, give st	reet and nu	mber)		4b. City, Town, o	or Location of	of Death		1	County of Deat	h
			903 MArcy Aven		201			0xon				Pı	ince G	eorges
	Funeral Director		5. Social Security Number  579-15-2377  Usual Residence of Decedent	6. Sex	M 2⊠F	7. Age (In yrs	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day 07 25	Year)	9. Birt Wash	hplace (State or Foreign puntry) ington, D.C.
	and		10a. State 10b. County			10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Mary f sho	jo	MD Prince	Geo	rges	(	Oxon Hi	11						1XYes 2 No
	the 28a	by Funeral Director	10e. Street and Number					10f. Zip Code				10a, Citiz	en of What Co	euntry?
	3e or		903 Marcy Aver	nie f	£201			20745				US		,
	ms 2	era	11. Marital Status		2. Was Deci	edent Ever in l	J.S. 13.	Was Decedent of F f Yes, specify Cub	lispanic Ori	gin? (Spe	ecify Yes or No-		4. Race - Ame	
စ	after or Ite	Ē	1 ☑ Never Married 2 ☐ Mar	ied	Armed Fo	2 🛛 No					Rican, etc.)		Black, White	
8	ral', c	by	3 Widowed 4 Divorced		if Yes, Gir Year or D	ve ates:		1⊡ Yes 2⊠ No	Specify:			,	Specify: Bla	ick
5-0	72 h	Completed	15. Deceden (Specify only highe				16a. Dece	dent's Usual Occup	oation during mosi	t of worki	na	16b. Kin	d of Business/	Industry
2	nithin ne.	Jdu	Elementary/Secondary (0-12)	Ť	College (	1-4or 5+)		kind of work done DO NOT use retire	d)				Mone	
7	led w lygiei her ti	S	11th.				Sti	ident					None	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other then "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examinal must be notified at once.	To Be	17. Father's Name (First, Middle, Unknown	Last)					Vic	tori	e (First, Middle, a Faulk	ner		
Jar	2 sh and le m reum		19a. Informant's Name/Relations		e, Print)		19b. Mailir 903 1	ng Address <i>(Street</i> Marcy Ave	and Numbe	or or Rura	on Hill	, City or Md	Town State 2	Zip Code) )
e)	l and fealth im 27 her t		Victoria Faulk	iei		20h		sition (Name of	,,					
Baltimore,	if its		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		moval from	State	cemetery, crei	natory or other pla			ate O.4		ation - City or	
ij	t. Pa rtmer rtant		<ul><li>4 □ Donation 5 □ Other (S</li><li>21. Signature of Funeral Service</li></ul>			Maı		National	1	11-12			el, Md	
Ba	permi Depa Impo any ir		0 0	6	7 10			. Name and Addre						
			23a. Parti Enter the disease, or	-	ations that o	aused the dea		217 9th.					D.C. 2	Approximate
Ь			shock, or heart failure. List Immediate Cause (Final	only one	cause on e	each line.			· g,			-		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	_ a.	_	(or as a conse		n Tumor						
В	Examiner				Due 10	(or as a conse	querice oi):							
		ler	Sequentially list conditions, if any, leading to immediate	b.		(or as a conse	quence of):							
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S c.										
oʻ	an an rial-tr	Exa	resulting in death) Last		Due to	(or as a conse	quence of):							
8760,	cate be executed physician and the burial-transit	cal		d.										
9	ng ph as th	Ned	IF FEMALE:	-										
Вох	eath certific attending p	an/h	23b. Was decedent pregnant	230		tcome of pregn		Ectopic pregnance	,			23	Bd. Date of deli	
	e dea he at led fo	sici	in the past 12 months? 1 ☐ Yes 2 ☒ No			nant at time of		Other (specify)					Month	Day Year
<u>Р</u>	that the de led by the a detached t	Physician/Med	9 Unknown				- Min - In Min - I				ana Dista			45
ŝ	Se Log	by	Part II. Other significant condition	ons contr	ibuting to di	eath but not re	sulling in the u	nderlying cause giv	en in Part i.					the cause of death?
Records,	w requir been si should	Completed									-		1140 3 114	
Sec	e law has b	npi									24a. Was a autops	SV	prior to c	topsy findings available completion of cause of
E	: The	Cor									1 Tes		death? 1 ☐ Yes	2 🗆 No
<u>Ş</u>	icien sertifi ector	Be	25. Was case referred to medica examiner?		spital:			0"			(Check only or			
ot	this cal dir	2	1 ☐ Yes 2 ½ No	HO	. 1		ER/Outpatier				ne 5 Reside			city)
u C	ding Phyeicien: The h.h. h. After this certificate ha funeral director, page	lon	27. Manner of Death  1 XNatural 5 Pendin		(Mon	of Injury th, Day Year)	28b. Time of Injury	Wor			28d. Describe h	ow injury	occurred	7
<u>s</u>	or Attending Physicien: ifter death. Director: After this certification by the funeral director,	Icat	2 Accident investig	not be	On Diese	of laine. At h	iomo form etc		Yes 2 □ N		29f Location /S	root and	Alumbor or Du	ral Route Number,
Division of Vital	after Direct In by	Certification:	4 Homicide determine	ined	buildi	ng, etc. (Speci	ify)	eet, factory, office		1	City or Town	, State)	realinger or Au	rai Houle Number,
_	Hospite 4 hours Funerel ely fillec	edical C	29a. Certifier (Check only one)  Certifyir  2 Medical	g Physic Examine	er: On the b	asis of examin	owledge, death	occurred at the tire	ne, date and	d place, a	and due to the c ed at the time, d	ause(s) a ate and p	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifie	r	and man	ner stated.		29c. Licens	e number		2	9d. Date	signed (Month	i, Day, Year)
	⊢ 3 ⊢ ŏ		Dennin		R	111-	-111			CC		1.1		2004
,			30. Name and address of person	who com	pleted caus	se of death (Ite	m 23a) (Tune		7 1335	76		11.	- 12	2007
-	0		Francisco					,	NT T.7	1.7 -	hington	. n	C. 200	0.7
		te	31. Date filed (Month, Day, Year)		2. R	egistrar's Sign	ature		• N • W •	- was	mrn8 rol	ه لليوا	U. ZUUI	01
	s Sta		NOV 1 7 2											

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician JEFFRY EARL FOUNTAIN November 9, 2004 5:27 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 1 XM 2 □ F Yrs. 49 Director June 4, 1955 Washington, DC 212-66-7788 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 □ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8863 Baltimore Road 21704 U.S.A. or items 23s Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White by 3 Widowed 4 Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry iit. Pages 1 and 2 should be filed within riment of Health and Mental Hygiene. crtant: If item 27 is marked other then injury or other traumatic event, Ital M. Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James M. Fountain, Jr. Florence F. Branin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Greendale Place, Greenbelt, Maryland 20770 Florence F. Thompson - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery 11/12/2004 Adelphi, Maryland permit.
Dep rtr.
Importe
any inju 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) 1 Day /Medical Due to (or as a consequence of): Examiner Hepatic Cirrhosis o Years Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury Qualto (or as a nonsequence of) Examiner attending physician and for use as the burial-transit death certificate be executed Hypertensive Heart Disease 4 Years that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Year in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24a. Was an autopsy performed?
1 Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide Hospital within 24 hours a 29a. Certifier 🖾 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) tle of certifier 29b. Signature and D36421 November 15, 2004 MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9093 Ridgefield Drive #104, Frederick, MD 21701 James Amerena, M.D. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 7 2004 Registrar

		•	For State Registrar	State of	Maryland / [		rtment of F				jiene ()	04	38165
	Dhysisi		1. Decedent's Name (First, Middle	Last)					2	2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic			Rein Fran						Novembe	er 4, 2		9:20 A. M
	Examin	er	4a. Facility Name (If not institution	-			4b. City, Town, o		of Death		4c. Count		
			Hebrew Home of 5. Social Security Number		Vashington '. Age (In yrs. last bin		Rockvi If Under 1 Year		24 Hrs.   9	B. Date of Birth		gomer	-
	Funeral Director		577-28-5026	1 M 2 F		Yrs.	Months Days	Hours	Min.	(Month, Day Feb. 5	Year) 1910	Pola	place (State or Foreign atry)
١.		1	Usual Residence of Decedent	A	24					reb. J	, 1910	1018	ind
	yland		10a. State 10b. County		10c. City, Town	n or Loc	cation					1	0d. Inside City Limits
	a-fs	ctor	Maryland Montg	omery	Rockvi	.11e							1 Yes 2 No
	or 28	Olre	10e. Street and Number				10f. Zip Code			1	l0g. Citizen of		ntry?
	23a	Funeral Director	6121 Montrose R				20852				U.S.		
	tems	nue	11. Marital Status	Armed For		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Ori an, Mexicar	gin? (Speci 1, Puerto Ri	ify Yes or No- can, etc.)		ce - Americ ick, White,	
36	rs aftr	by F	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 ☐ Yes If Yes, Give Year or Da	<del>-</del>	1	☐ Yes 2X No	Specify:			Specia	fy: Wh	ite
5-0036	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show Jisal Exa. ilhetr aust be notified at	ed	15. Decedent	's Education	37	Deced	ent's Usual Occup	ation			16b. Kind of B		
215	hin 72	plet	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-	4or 5+)	(Give I	kind of work done OO NOT use retired	during mos d)	t of working	,			
2121	giene grene er the	Completed	12 Years				Homemake	r			Own H	ome	
nd	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, I			1. 7	- \				<sub>Maiden Sumai</sub> Unascer		.1.1.
yla	Men Men Marke	٩	(Unascertaina		nascertain			Ro		`			
Maryland	id 2 sh Ith and 27 is rr traum		19a. Informant's Name/Relationsh Jeffrey L. Rein				g Address <i>(Street</i> Forest M						20707
ē,	Hear Hear		20a. Method of Disposition		comoto		sition (Name of natory or other place	rei l	Da	te	20c. Location	- City or To	own, State
e E	Pages ent of ry or it		1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (St		King D	avi	d Mem. G	arden	11/1	1/2004	Falls	Chur	ch, Va.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show eny injury or other traumatic event, it is Mudical Exa. illier is as the notified at once.		21. Signature of Funeral Service I	Stotte	emyer	1		ville	Pike	, Rocky	ville,		and 20852
	100		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	us the death. Do i	not ente	er the mode of dyin	ng, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		eroscleretic								Onset and Death
	/Medical Examiner		resulting in death)		or as a consequence								
P.	LAUITINICI	<u>.</u>	Sequentially list conditions,	b. Due to (	or as a consequence	of)·							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (t	n as a consequence	01).							
	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	CDue to (c	or as a consequence	of):							
8760	ate be ex hysician he burial	ical		d									
9	certificate iding phys ise as the			1						- 4			
Вох	eath certifica attending pl for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 Fetal death	3□	Ectopic pregnancy	,			l l	ate of delive	ory Day Year
.O. E	the attenthed for u	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregna 9□ Unkno	ent at time of death	5 🗆	Other (specify)		-		l l	oriu i	Day Teal
Δ.	that the de ed by the detached		Part II. Other significant condition	ns contributing to de	ath but not resulting in	n the un	nderlying cause giv	en in Part I		23e. Did to	bacco use con	tribute to th	ne cause of death?
ecords,	equires that sen signed I tould be det	d by								1 🗆 Y	es 2 🗆 No	3 ☐ Prob	ably 4 Hinknown
00	S b	Completed								24a. Was a	ın 24b.	Were auto	psy findings available
$\alpha$	0 + 0	шć								autops	med?	prior to con death?	npletion of cause of
Vital	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical					26 Place	of Death (	1 ☐ Yes Check only or		1 🗆 Yes	2□ No
>	Physician: this certific al director,	o B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 Ir	ipatient 2 ☐ ER/Ou	ıtpatien	t 3 DOA Oth				ence 6 Ott	ner (Specifi	/)
101		n; T	27. Manner of Death 1 DNatural 5 Pendin	28a. Date o		Time of njury	28c. Injur Wor		-		ow injury occur		
io		atlc	2 Accident investig	gation		,,		Yes 2	No				
Division of	or Atter de Directe in by the	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place	of Injury - At home, fa g, etc. (Specify)	ırm, stre	eet, factory, office		28	f. Location (Si City or Town	treet and Numi n, State)	ber or Rura	l Route Number,
D	pitel or At ours after o terel Direc	S											
	Hos 14 h Fur tely	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To the Exeminer: On the ba and mann	sis of examination an	e, death id/or inv	occurred at the tir restigation, in my o	ne, date an pinion, dea	id place, an ith occurred	d due to the c I at the time, d	ause(s) and m ate and place,	anner as si and due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certified	10 /-			29c. Licens			2	9d. Date signe	ed (Month,	Day, Year)
	(0		/ Com	B WM		D.	1 40	125		1	buembe	r 4,	2004
	Ψ		30. Name and address of person	who completed cause	of death (Item 23a)		Print)	R	ocki.	145	narul	Aur	20453
	Sta Regist		31. Date filed (Month, Day, Year)	04 32. Re	egistrar's Signature	, 100	parte	. 1/5	(1-0-)	00	11.70	/1 /0  2	0-13 3-
	negist	ell .	MON TO SO	04	/-								

			State of Manyland / D	epartment of Health and Me	•	•	
			, 101	Certificate of Death	Reg. N	21116	38166
		2	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Ď.	Physicia /Medic		Donald Shirley Frye		ovember 1	2, 2004	6:25 PM M
•9	Examin	ęr	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	
	Funeral		Southern Maryland Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birth			rince Geo	lace (State or Foreign
Ľ	Director		5/8-40-408/ /4	rs. Months Days Hours Min.	Sept. 4,	1930 West	Virginia
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		1	0d. Inside City Limits
	a-fsh	ctor	Maryland Prince George's Accoke	eek			1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Cour	ntry?
	eath v		105 Biddle Road  11. Marital Status 12. Was Decedent Ever in U.S.	20607	ify Yes or No-	USA 14. Race - Americ	an Indian
က	after d	Funeral	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.)	Black, White,	etc.
003	ural', c	d by	3 ☐ Widowed 4 🛣 Divorced If Yes, Give Year or Dates: 1951-53	1 ☐ Yes 2 <b>X</b> ☐ No Specify:			ite 
15-(	filed within 72 hours after death with the Maryland Hygiene. ythar than "natural", or Items 23a or 28a-1 show ant, It's Madical Exercit vermat be mutified at	Completed by	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/In	dustry
212	d with giene. ar thar	ome	Elementary/Secondary (0-12)   College (1-4or 5+)	ef Engineer	D(	C Governm	ent
nd	be file	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (		•	
ryla	hould d Men marka matic	<sup>2</sup>	Clyde Newman Frye  19a. Informant's Name/Relationship (Type, Print)  19b. 1	Mary Cle Mailing Address (Street and Number or Rural I	emens Bai		Code
Z	nd 2 salth an 27 is i			.05 Biddle Road, Accok			Code)
e,	es 1 and 2 of Health a litam 27 is rothar trau			Disposition (Name of Date of Crematory or other place)		_ocation - City or To	wn, State
Baltimore, Maryland 21215-0036	ment tant: It jury o		'4 Donation 5 Other (Specify) Mary la	nd Veterans Cem 11-18	3-04 Che	ltenham,	MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avant, If a Modical Exercitive resist to itemit of a gone.		21. Signature of Funeral Service Licensee M00053	22. Name and Address of Facility Huntt Funeral Home P. O. Box 156, Waldo	orf. MD 20	0604	
	*		23a. Part1 Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	LANOXIA			Oriset and Death
ı	Examiner		Due to (or as a consequence of	UC HEART FAT	1		
	₽ #	ner	Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury	1.	CURC		
	and A-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of	f):			
760,	ate be executed hysician and he burial-transit	cal E	d	,			
89	rtificat ng phy as the		IF FEMALE:				
Вох	that the death certificat ed by the attending phy detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy		23d. Date of delive Month	ry Day Year
o	the de	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death	5 Other (specify)			
Д.	res that signed b	by Pl	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the	e cause of death?
ord	w require been si should b				1 ☐ Yes 2	Prob	ably 4 Unknown
Vital Records,	2 2 2	Completed			24a. Was an autopsy performed?	prior to coi death?	psy findings available inpletion of cause of
/ital	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical examiner?	26. Place of Death (	Check only one)		
	Attanding Physician: rr death. actor: After this certific. by the funeral director.	. To	1 ☐ Yes 2 € No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 □ DOA Other: 4 □ Nursing Home me of 28c. Injury at 28	5 Residence d. Describe how inju		/)
ion	nding tth. :: After	atlon		ury Work? M 1 Tyes 2 No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division of	i Dift	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	f. Location (Street a City or Town, Star	nd Number or Rura 'e)	l Route Number,
	To tha Hospital within 24 hours a To tha Funaral Completely filled	edical C	29a. Certifier  1 Certifying Physician: To the best of my knowledge, (Check only  Medical Examiner: On the basis of examination and				
	To tha within 2. To tha complet	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. D.	ate signed (Month,	Day, Year)
	¥ 3 F 8		> Shref (former, MO	D50862			, 14,2004
1	- I.		30. Name and address of person who completed cause of death (Item 23a) (T				
ì	B ILE	to	Dr. Sherif Hassan, 9831 Greenblet 31. Date filed (Month, Day, Year) NOV 1 6 2004 32. Poistrar's Signature	Road, Suite 103, Lanh	am, MD 20	706	
	Registr		NOV 1 6 2004	Agreement			

	1	For State Registrar	State of N	Marylan		artment tificate			and M		Reg. No. 0 (	) 4	3816
Physician /Medical		1. Decedent's Name (First, Middle Chester		Allen			Fishe			2. Date of Dea Month November	Day r 16, 200		3. Time of Death 2:00 A
Examiner Funeral		Country Hous  5. Social Security Number	e Residences		last birthday) Yrs.	4b. City,  If Under  Months	Cum	berlan  If Under	ıd	8. Date of Birt (Month, Da 01/27/19		legan 9. Birth Cou	
Director	-	167-03-5036  Usual Residence of Decedent  10a. State 10b. County  MD A11eg.			ty, Town or Lo	cation				01/2//19		Peni	10d. Inside City Limit
uter death with the Mar r trams 23e or 28e-f e riner rout be indiffed Euneral Director		10e. Street and Number	Ridge Road,	NW		10f. Zip		21502			10g. Citizen of V		intry?
S	2	11. Marital Status 1 □ Nøver Married 2 □ Marr 3 ሺ Widowed 4 □ Divorced	12. Was Decede Amed Force ed 1 Tyes 2 If Yes, Give Year or Date	No No		Was Deced f Yes, spec 1 \( \text{Yes} \) 2		spanic Ori n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)	Specify	ck, White	ican Indian, , etc. White
ed within 72 houygiene.  er than "nature" t, the Medical E	on bletch	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (1-40	or 5+)	(Give	dent's Usua kind of wor DO NOT us Account	rk done d se retired	luring mos	t of workii	ng	16b. Kind of B		
od 2 should be file tith and Mental Hy 27 is marked other traumatic evant, To Re	ב	17. Father's Name (First, Middle, Albert	Lewis			Sisher	(Ctanat o	Sara	ah	El	Maiden Suman izabeth er, City or Town,		Kemper
t and 2 sh Health and tam 27 is m		19a. Informant's Name/Relations: Ruth F. Brown / da 20a. Method of Disposition	ughter			7 Stone	eybroo	ok Lan	e, La	Vale, MD			
permit. Pages Department of Important: If i any injury or once.		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	ite .	mberland	Crema	atory d Addres	1: s of Facilit		ns Family	Cumberla Funeral	Home,	F.A.
9 9 E # 9	1	23a. Pert1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that cause on gas	ed in e dear	th. Do not ent	er the mod	e of dyin	g, such as	cardiac o	r respiratory ar	and, MD rest, DISTAL		Approximate Interval Between Onset and Death
auth certificate be executed attending physician and for use as the burial-transit of the complex transit	Ical CAa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a consec									
w requires that the death certificate been signed by the attending phys should be detached for use as the	iyalcıdırı	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 □ Fete tat time of c	el death 3	Ectopic pr Other (sp						te of deliv	very Day Year
requires that sen signed to yould be delt	ied by r	Part II. Other significant condition	ons contributing to deat	h but not res	sulting in the u	nderlying c	ause give	en in Part I	· 		obacco use conf		the cause of death?  bably 4 □Unknow
The lay	Completed									1 Yes	rmed?	Were aut prior to co death? 1  Yes	opsy findings availab ompletion of cause of 2 No
ng Phys Iter this Ineral dii	0 2	25. Was case referred to medica examiner?  1  Yes 2  10  27. Manne	g 28a. Date of I (Month,		ER/Outpatier 28b. Time o Injury	_	8c. Injun Worl	9r: 4 🗆 Nu	rsing Hor		dence 6 Doth		iy) Living
To the Hospital or Attandi within 24 hours after death.  To the Funeral Director: A completely filled in by the tu	Cerumcation;	3 Suicide 6 Could 4 Homicide determ	288. Place of	Injury - At h , etc. (Speci	nome, farm, sti	eet, factory	, office			28f. Location (S City or Tox		er or Rui	ral Route Number,
the Hospi hin 24 hour tha Funar npletely fill	Medical	(Check only 2 Medical one)	g Physicien: To the be Examiner: On the basi and manner	s of examina		vestigation	, in my o			ed at the time,		and due	to the cause(s)
Variety Sounds	5	29b. Signature and the of certifie	v Pitys	CV/				D50844			November		
n 2s			ria, M.D., 9		on Drive	, Cumb	erlan		2150	2			

				State of Maryland / Department of Health an  1 - For State Registrar  Certificate of Death	nd Mental H	lygiene 004	38168
				1. Decedent's Name (First, Middle, Last)	2. Date of Month		3. Time of Death
		Physicia		Roman Michael Garbade	Novem		0845 A <sup>M</sup>
		/Medic Examin		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of D	Death	4c. County of Dea	
_				Harford Memorial Hospital Havre de Grac		Harford	
		Funeral			Min. (Month,	Birth 9. Bir Day, Year) C	thplace (State or Foreign ountry)
		Director	}	221-30-1966 58	AUG 1	2, 1946   Ger	many
		and and	1	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
		Maryl 1 sho	ō	Maryland Cecil Perryville			1 XYes 2 ☐ No
		the 28e	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
		38 o	D	634 Cole Street 21903		United	States
		deat	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or Puerto Rican, etc.)	No- 14. Race - Am Black, Whi	
	9	or It	显	1 XNever Married 2 Married 1 ∏ Yes 2 XNo 1 Yes 2 No Specify:			hite
oma	5-0036	urat',	d by	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation		16b, Kind of Business	
$\succeq$	15-	"net	jete	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	f working	Cosmetics	
0	2121	be filed within 72 hours atter death with the Maryland ital Hyglene.  d other than "netural", or items 23e or 28e-f show event, if a Medical Examinar must be notified at	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)   Production		Manufactu	ıring
a	<b>d</b> 2	filed Hyg other	BeC	17. Father's Name (First, Middle, Last)  18. Mother's	Name (First, Mide	dle, Maiden Sumame)	
2	lan	Aenta Aenta Treed	To B		arete Gal		
0	Maryland	2 should and Men ts marke eumatic	-	Edward 19b. Mailing Address (Street and Number of Ward 19b. Mailing Address)			
Sade		es 1 and 2 should be filed of Health and Mental Hygis If item 27 ts marked other or other treumatic event, I		Attorney 131 East Main Stree			
	ore	ot He		Illiburial 2 (Alcremation 3 Libertoval from State   It. A. 1 CIII S C	ovember	West Chest	
2	Ë	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artenet of Health and Mental Hygiene. ortent: if item 27 is marked other than "neturat", or items 23e or 28e-1 show injury or other treumatic event, if the Medical Examinat must be notified at injury or other treumatic event, if the Medical Examinat must be notified at .		`4 □Donation 5 □Other (Specify) Co. Inc. 23	3, 2004	Pennsylvan	nia
- K	Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for F	unerals,	P.A.	4 1 019004
		40240		23a, Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as call	Street,	Elkton, Mary varrest	Approximate
				shock or heart failure. List only one cause on each line.			Interval Between Onset and Death
		Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a. CHPOUL OBSTRUCTIVE Due to (or as a consequence of):		2 1/11eas	grs
		Examiner					
			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
1 0		ate be executed hysician and the burial-transit	Examin	that initiated events			
To	0,	be exe ician a burial-	Ě	resulting in death) Last Due to (or as a consequence of):			i
$\infty$	8760	cate b	dicai	d			
0	x 68	certifical oding phy use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	alivery
1	Вох	eath atten	Physician/Med	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy		Month	Day Year
5	O.	the d y the tched	Jyst	1 Yes 2 No 9 Unknown			
0	ls, P	sicien: The law requires that the death certifica certificate has been signed by the attending ph rector, page 2 should be detached for use as it		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. D	id tobacco use contribute	to the cause of death?
2	rds	w require been sig should b	edt	Kyphos1s	1	©Yes 2□No 3□F	robably 4 Unknown
	O O	aw re	Completed by	STAPA SEPSIS		utopsv prior ta	utopsy findings available completion of cause of
_	Ä	The ate has page	E O		ρι 1 □ Ye	erformed? death? is 2 No 1 □ Ye	s 2 No
	/ita	ertitic octor.	Be (	examiner?	f Death (Check on		
	£	Physicien: r this certitic ral director.	은		-	esidence 6 Other (Sp. be how injury occurred	ecify)
	N C	ling P	lon	1 Description (Month, Day Year) Injury Work?		bo now analy occurred	
	Division of Vital Record	Attending r death. ector: After by the fune	Certification:	2 Accident and accident a livestigation and a suicide a Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Locatio	n (Street and Number or F	Rural Route Number,
	Θį	alter alter Dire	erti	4 Homicide determined building, etc. (Specify)	City or	Town, State)	
		To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certilicate has completely filled in by the funeral director, page 2		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and for the control of the	place, and due to to	the cause(s) and manner a	s stated.
		he Ho in 24 he Fu pletel	edical	one) and manner stated.			
		To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier		29d. Date signed (Mor	21,7104
	7	1		Macket Kenk by NA DIKOJ6	1-5 0	2-11-25	ill D
		5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 dell 3836 CHURCHVILE ROAD CHURCHVILE, M.	AYLAN	ANTOS PI	, , , , ,
		9+	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
		Regist		DEC 02 2004 Server & Sometil			

		For		State of	Marylar	-	rtment of H			ntal Hy		11	00160
		State     Registrar  1. Decedent's Name	/Eirnt Mindello	(		Cer	tificate of	Death		Date of Dea	109.110.	] [ ]	38   69 3. Time of Death
Physicia		Fran	Llia	Gorde					2.	Month	Day	Year	11:25 A M
/Medic Examine		4a. Facility Name (II		give street and num	ber)		4b. City, Town, o	or Location of	of Death		4c. County o	f Death	
		5. Social Security N	// *.	S. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under	24 Hrs.   8	Date of Birt	Men	4	(State or Foreign -
Funeral Director		214-28-9		1⊠M 2□F	71	Yrs.	Months Days	Hours	Min. M	(Month, Day AR 2	1933	Countr	VA
and w.		Usual Residence of 10a. State	Decedent 10b. County		10c. Ci	ty, Town or Lo	cation					100	d. Inside City Limits
Maryi a-f eho	tor	MD	MONTG	OMERY	s	ILVER	SPRING						1 ☐ Yes 2 ☑ No
with the	Il Direc	10e. Street and Nun 3210 KA		STREET			10f. Zip Code 20906				10g. Citizen of WI	hat Countr	y?
paritimore, Intellylating A.I.A.I.3-0030 permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exptr. or must be notified at once.	by Funeral Director	11. Marital Status  1 Never Marri 3 Widowed		12. Was Dece Armed For  1 Yes If Yes, Giv Year or Da	ces? 2 No e		Vas Decedent of H Yes, specify Cub			y Yes or No- an, etc.)	Black	- Americar , White, et	c.
thin 72 hou	Completed			s Education grade completed)	-4or 5+)	(Give	lent's Usual Occup kind of work done OO NOT use retire	during mos	at of working		16b. Kind of Bus		ŕ
ba filed will tall Hygien d other th	Be	Elementary/Seconds 17. Father's Name ( HARRY (	First, Middle, L	ast)	M	DRI	V E K	1	er's Name <i>(F</i>		Maiden Sumame		
marke	မ	19a. Informant's Na	<del></del>	p (Type, Print)		19b. Mailin	a Address (Street	-			er, City or Town, S	itate. Zip C	(ode)
Md 2 sauth an 27 is or trau		MARY FUC		DAUGHTER	}						SPRING,		
Pagas 1 sent of He not: If item		20a. Method of Disp 1 ☑ Burial 2 ( ` 4 ☐ Donation	Cremation	3 □Removal from :		cemetery, cren	sition (Name of natory or other pla Y CEMET	ERY	Date 11/18		BEALLS	-	
permit. Pagas permit. Pagas Department of Important: If it any injury or once.		21. Signature of Fu	neral Service	cense		H.	Name and Addre	UNERA	AL HO		LE, MD	20:	838
1		23a. Part1. Enter the shock, or hear	ne disease, or o	omplications that can't one cause on e	aused the dea ach line.							Í	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause ( disease or condition resulting in death)		a. A.	CVA								Diset and Death
Examiner					or as a consec	quence of):							
D #	iner	Sequentially list con if any, leading to im cause. Enter Unde	riving	Due to (	or as a consec	quence of):							
axacute	Examiner	Cause (Disease or that initiated events resulting in death) l		c. Due to (	or as a consec	quence of):							
te be e ysician	cal		A	d									
A od entifica ding ph	/Med	IF FEMALE:		23c. If ves. out	come of prean	2004							
S, F.O. BOX 00/00, es that the death certificate be exacuted igned by the attending physician and be detached for use as the buriat-transit	Physician/M	in the past 12 1 Yes 2 Unknown	months? ⊒No	1☐Live b	irth 2 ☐ Feta ant at time of c	aldeath 3□	Ectopic pregnanc Other (specify) _	у			Mont	of delivery h D	ay Year
that the ned by detacl		Deet II. Other signif	icant condition	s contributing to de	ath but not re	sulting in the ur	nderlying cause gr	ven in Part I	i.	23e. Did to	obacco use contrib	oute to the	cause of death?
w requires baen signoshould be	ed by	- per	sphere	l VASCUL	a dis	care				1 🗆 Y	∕es 2□No 3	B 🗀 Probat	oly 4 Onknown
has has	Completed	Hy,	perten	Sico.		· · · · · ·				24a. Was autop perfor 1  Yes	psy pri rmed? de	ere autops ior to comp ath? Yes _2	y findings available pletion of cause of
	BeC	25. Was case refer	red to medical	Marrian					e of Death (C				
hy hy	2	1 Yes 2 2		28a. Date	of Injury	ER/Outpatien 28b. Time of	1 SE DOA				dence 6 Other		
tending leath. for: Afte the fune	ation	1 Natural 2 Accident	5 Pending investig	(Mont	h, Day Year)	Injury		rk? ]Yes 2□					
al or Atte s after dea il Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	and Zoe. Place	of Injury - At h	iome, farm, stre	eet, factory, office		28f.	Location (S City or Tox	Street and Number vn, State)	r or Rural F	Route Number,
To the Hospital or Attending P within 24 hours attended in 70 the Funeral Director: Affect completely filled in by the funeral	edical (	29a. Certifier (Check only one)		Physician: To the xaminer: On the ba and man	sis of examin-								
Totl within Totl comp	W	29b. Signature and		(us) E	negen	cg verm	29c. Licens	D005	0410		29d. Date signed	(Month, Da	ay, Year)
		30. Name and addr	011	the completed caus	e of death (Ite	m 23a) (Type,	Print) General	1 tesp.	he	Olne	es MI	)	
Sta Registr		31. Date filed (Mon		1 7 2004)	egistrar's Sign	ature /	B 4	oak.					

State of Maryland / Department of Health and Mental	Hygiene n n I.
Cortificate of Dooth	2004

71		For State		State o	of Mar	yland / D	)epa	rtment of F	lealth a	nd Mental H	ygier	rez ()	104	381	70
		Registrar					Cer	tificate of	Death	1 - 5 - 1	Reg. I	No.			
Physici	an	Decedent's Nam     TTDCTN:			T 3 3 7 CT	OMB				2. Date of I Month	- 1	Day	Year	3. Time of D	
/Medic		VIRGIN			IANSR	OTE				NOVEME			2004	1:50	<b>A.</b> <sup>™</sup>
Examin	er			n, give street and nu		-		4b. City, Town, o		Death			ty of Death		
				N AVENUE,		In yrs. last birt	ab of a ch	CUMBER		4 Hrs. 8. Date of I	Dieth.	ALı	LEGAN	Y plece (Stete or	Comina
Funeral Director		5. Social Security N 215–26–6	5996	6. Sex 1 ☐ M 2 🔀 F			Yrs.	Months Days	Hours	Min. (Month, JAN 1	Day, Yea	931	Cou	YLAND	roreign
pur &		Usual Residence of 10a, State	f Decedent 10b. County		1	Oc. City, Town	n or Loc	cation						10d. Inside City	v Limits
Aaryla f who	o	MD		EGANY		CUMB								1 ☐ Yes	
the N 28a-	rect	10e. Street and Nu						10f. Zip Code			10g.	Citizen of	f What Cou		
ours after death with the Marylan ral', or Items 23a or 28a-f ≢how Ex. ulther trivist be notified at	Funeral Director			ION AVEN	NUE,	S.W.		21502	2			U.S	.A.		
dea ms	ner	11. Marital Status		12. Was Dec Armed F	edent Ev	er in U.S.	13. V	Vas Decedent of H	lispanic Orig	in? (Specify Yes or Puerto Rican, etc.)	No-		ace · Amer	ican Indian,	
after or Ite		1 Never Marr		ried I∏Yes	21 No			☐ Yes 2 XNo		, , , , , , , , , , , , , , , , , , , ,		Spec		ITE	
ural',	d by	<b>3</b> VVidowed			Dates:	-05					245	1	. ,,,,,,		
72 hours "natural",	lete	(Spec	15. Deceden city only highe	t's Education st grade completed)	)	16a.	(Give )	ent's Usual Occup kind of work done OO NOT use retired	ation during most	of working	16b	. Kind of	Business/Ir	idustry	
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or ttems 23a or 28a-f ehow ant. The Musical Ex. ultret is ust be notified at	Completed	Elementary/Seco	ondary (0-12)	College (	(1-4or 5+)			1EMAKER	3)			ном	ſΕ		
Hyg other	a	17. Father's Name	(First, Middle,	Last)					18. Mother	's Name (First, Midd	ile, Maio	len Suma	ime)		
old be fenta rkad rlc ev	To B	ROBERT	r for	EBECK					MAR	GARET RO	DBY				
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event. Ite Medical 800c.		19a. Informant's N CAROLE		hip (Type, Print)  / DAUGHTI	ER	19b. 13	Mailin	g Address (Street BOWLING	and Number	or Rural Route Num	nber, Cit LANI	y or Town	n, State, Zi	p Code) 502	D46 411.
s 1 ar		20a. Method of Dis				20b. Place of	Dispos	sition (Name of patory or other place	cel	Date 2004	20c.	Location	- City or T	own, Slate	
Pages ment of ant: If i		¥⊠Burial 2 4 □Donation		3 □Removal from Specify)	State	SUNSET	ME	MORIAL P	ARK 11	/18/ <del>204</del>			ERLAN.	D, MD	
permit. Departi		21. Signature of Fe	neral Service	Licensee	her	rel	22	Name and Addre UPCHURCH 202 GREE	FUNEF	RAL HOME, REET, CUME	P.A. BERL	AND,	MD	21502	
	JUSTIVE	23a. Part1. Enter to shock, or hea	the disease, or art failure. List	complications that	caused the	ne death. Do r	not ente	er the mode of dyin	ng, such as c	ardiac or respiratory	arrest,			Approximate Interval Between	reen
Physician	16	Immediate Cause	(Final			TAGE	- 14	LIDNEY	01	SEASE				Onset and De	
/Medical		resulting in death)				consequence				70 102			-	2 1	- ( ) (
Examiner		Sequentially list or	anditions	b											
p #	ner	Sequentially list con any, leading to ir cause. Enter Undo Cause (Disease or	nmediate erlying	Due to	(or as a	consequence	of):								
acute ind trans	Examiner	Cause (Disease or that initiated event resulting in death)	5	C			-								
e exe		resulting in death)	Lasi	Due to	or as a	consequence (	of):								
ate b hysic the b	dlca			d											
hat the death certificate be executed d by the attending physicien and Jetached for use as the burial-transif	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1  Yes 2	2 months? ☑ No		birth 2 mant at tir	pregnancy Fetel death		Ectopic pregnancy Other (specify)	y		-		ate of delive	-	ear
hat to	P			ons contributing to d	death but	not resulting in	the un	iderlying cause div	en in Part I	23e. Di	d tobacc	o use co	ntribute to	the cause of de	ath?

neral Director: After this certificate has been signed by the atterifiled in by the funeral director, page 2 should be detached for Be Completed

þ

2

Certification;

Medical

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

Car O. Burga

24 hours after death. • Funeral Director: A

within 24 hor To the Fune completely fi

Baltimore, Maryland 21215-0036

23e. Did tobacco use contribute to the cause of death?

21502

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 ☐ Inpatient

24a. Was an autopsy performed

26. Place of Death (Check only one,

1 Tyes

1 Yes 2 No

2 1 No

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes

25. Was case referred to medici examiner?
1 ☐ Yes 2 ☑ No
27. Mann of Death

5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 28b. Time of Injury

3□ DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

NOV 2 2 2004

			For Stete Registrar	State of Maryland /	Depa <i>Cei</i>	artment of	f Health a of Death	nd Me		ie <b>2</b> e)	04	3817	!
	Physici	an	1. Decedent's Name (First, Middle, Last						. Date of Deat Month		Year		
	/Medic	al	Richard Thom						ovember		2004		Ам
	Examin	er	4a. Facility Name (If not institution, give				n, or Location of	Death			unty of Dea		
			Montgomery Gener  5. Social Security Number 6. Se		hirthday)	01nder 1 Ye	•	4 Hrs. R	. Date of Birth	1 1	ontgo		Foreign
Н	Funeral Director			M 2□F 82	Yrs.	Months Da		Min	(Month, Day, ug. 12	1922	Ne	rthplace (State or Country) WYORK	roreign
	pu 💌	·	Usual Residence of Decedent  10a. State 10b. County	10c. City. To	own or Lo	cation						10d. Inside City	Limite
	Aaryla F shov	٥	Md. Montgo			Spring						1 Tes	
	28a-	rect	10e. Street and Number		· -	10f. Zip Cod			10	Og. Citizen	of What C	Country?	
	sa or		15410 Prince Fre	derick Wav			2090	6		_	ed St	-	
	ms 2	Jera	11. Marital Status	12. Was Decedent Ever in U.S.	13.	Was Decedent	of Hispanic Orig Cuban, Mexican,	in? (Speci	fy Yes or No-	14.	Race · Am	erican Indian,	
ဖွ	after or Ite	/Fu	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ⊠Yes 2 □ No lf Yes, Give WWII		ires, specily c 1 □ Yes 2121		ruento Mi	can, etc.)		Black, Whi ec <i>ify</i> :	white	
8	hours tural',	Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edi	Year or Dates:	Ra Dagge	dent's Usual Oc					of Business		
7	in 72 n "na nadic	piet	(Specify only highest grad	de completed)	(Give	kind of work do DO NOT use re	ne during most tired)	of working		TOD. PAING C	ii Dusiiless	sindustry	
212	d with giene. ir that	lmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Aud:	itor				0	il Co	mpany	
2	al Hy	Be	17. Father's Name (First, Middle, Last)						First, Middle, A				
yla	ould t Meni	2		unt, Sr.			Mang eet and Number			Johns			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "neturel", or Items 23a or 28a-f show amounts in Item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or gher traumatic avant, the Madical Examinar must be notified at once.		19a. Informant's Name/Relationship (7) Frances S. Hunt				e Fredei						20906
ē,	s 1 an f Heal Itam 2		20a. Method of Disposition	20b. Place	of Dispo	sition (Name of natory or other	nlacel	Dat	е 2	20c. Locati	on · City o	r Town, State	
Ë	Page int: =		1 Burial 2 ☐ Cremation 3 1 Solution 1 Solution 2 ☐ Other (Specify	Hemoval from State		Cemete		11/17	/04 V	Vestf	ield,	New Jer	'sey.
alti	nmit. spartm porta iy inju		21. Signature of Funeral Service Licens	500	22	Name and Ad	dress of Facility	er Fu	neral H	lome			
	20E 29		Murel W. C	Sorhu		P. O. 1	Box 5038	8, La	ytonsv	ille,	Md.		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Done cause on each line.	o not ent	er the mode of	dying, such as o	cardiac or r	espiratory arre	est,		Approximate Interval Betw Onset and De	een
14	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a cerebra	.1	hemor	-hage					nine how	
b	Examiner			Due to (or as a consequence	20 017.	sion	J						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con resulence		310~						-	
	cuted nd ransit	Examiner	that initiated events	c									
90,	ate be executed hysician and the burial-transit	i Ex	resulting in death) Last	Due to (or as a consequence	ce of):								
8760,		dicai		d									
9 X	certifi nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy						23d.	Date of de	alivery	
Box	es that the death certific. Igned by the attending p be detached for use as t	Physician/Med	in the past 12 months?	1 Live birth 2 Fetal dea 4 Pregnant at time of death		]Ectopic pregna ] Other <i>(specify</i>					Month		ear
0.0	at the by th	hys	9 Unknown	9□ Unknown									
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ontributing to death but not resulting	g in the u	nderlying cause	given in Part I.		23e. Did tob	1/		to the cause of de Probably 4 □Ur	
ord	w requir been si should	eted											
of Vital Records,	ne law n has b ge 2 s	Completed							24a. Was ar autopsy perform	/	prior to death?		vallable use of
ā	yslcian: The is certificate hadirector, page	e Co	25. Was case referred to medical				26 Place	of Death /	1 ☐ Yes 2 Check only one	No	1 🗌 Ye	s 2 No	
>	/slcia s cert directi	o B	eyaminer?	Hospital: 1 X Inpatient 2 ☐ ER/	Outpatier	nt 3□ DOA	Dithora		5 Reside	-	Other (Sp.	ecify)	
סר	a th	n; T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		o. Time of Injury	f 28c. l	njury at Work?		d. Describe ho			,,	
Siol	eath. or: Af the fu	catic	2 Accident investigation 3 Suicide 6 Could not be				1 ☐ Yes 2 ☐ N						
Division	or Atl after d Diract in by	Certification;	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, str	eet, factory, offi	ice	28	City or Town	eet and No . State)	amber or F	Rural Route Numb	er,
_	spital ours a naral filled		29a. Certifier 1 Certifying Phy	ysicien: To the best of my knowled	ige, deatl	h occurred at th	e time, date and	i place, and	d due to the ca	use(s) and	manner a	is stated.	
	To the Hospital or Attending I within 24 hours after death.  To tha Funaral Director: After completely filled in by the funer	edicai	(Check only 2 Medical Examone)	iner: On the basis of examination and manner stated.	and/or in	vestigation, in n	ny opinion, death	h occurred	at the time, da	ite and pla	ce, and du	e to the cause(s)	
	Vithir To th	Š	29b. Signature and title of certifier				ense number					ith, Day, Year)	
	10+1			100.						Juves	سلهدم	13,20	Pioc
	41		30. Name and address of person who co	completed cause of death (Item 23:	a) (Type,	Print) Da				20	07.7		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature				/V 0	ery land	~	0 32		
	Registi		NOV 16 20		Ø	Span	KS						

			For State Registrar		State of Ma			irtment of F tificate of a			giene Reg. No		38172
	Physici		1 Decedent's Name	(First, Middle, Las	0065		-			2. Date of De Month		~ ~ Year	3. Time of Death
ı	/Medic Examin			f not institution, give	street and number)				r Location of Dear	th	4c.	County of Death	
	Funeral Director		5. Social Security N 317 • 44 • 00	071	ox 7. Ag S M 2□F	e (In yrs. last bir 60	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)		hplace (State or Foreign untry) diana
	land		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	Mary Filed	tor	Maryland	Montgome	ry	Silve	er S	Spring					12X∑Yes 2 ☐ No
	or 28¢	Director	10e. Street and Nur					10f. Zip Code			-	izen of What Co	untry?
	sath w			olly Grove	e Road  12. Was Decedent	Ever in 11 S	13 V	2090		Specify Ves or No		S.A.	rican Indian
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show amounts: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumetic event, the Medical Examinational Landing and ODGe.	by Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Marri</li><li>3 ☐ Widowed</li></ul>	ed 2☑ Married 4 □ Divorced	Armed Forces?  1 ⊠Yes 2 □ I  If Yes, Give †  Year or Dates:	No 1969		Vas Decedent of H Yes, specify Cuba ☐ Yes 2☑ No	Specify:	to Rican, etc.)		Black, White	e, etc.
5-0	netu	Completed	(Spec	15. Decedent's Ed ify only highest gra	ucation de completed)	16a.	Give	ent's Usual Occup kind of work done OO NOT use retired	ation during most of wo	rking	16b. K	ind of Business/	industry
121	within ene. then	ошо	Elementary/Seco	ndary (0-12)	College (1-4or 5 5+ Year			ool Teac			Edu	ıcation	
פֿ	e filed al Hyg other vent,	Be C	17. Father's Name	(First, Middle, Last)						me (First, Middle,	Maiden	Sumame)	
ylar	Menta	ToE	Morsel1	Emmett	Hodges				Thelma	Scott			
Mar	12 sho h and 7 Is m treum	1		ame/Relationship (7	Type, Print) dges/Wife			g Address (Street Holly G					
ē,	Healt tem 2		20a. Method of Disp		uges/ wile	20b. Place of	f Dispos	sition (Name of patory or other place	1	Date Date		ocation - City or	
ē	Pages ient of ry or			Cremation 3 ☐     5 ☐ Other (Specify)	Removal from State )	I	-			/14/04	Bren	itwood,	Maryland
Baltimore, Maryland 21215-0036	permit. Departrimporte any inju		Na	ineral Service Licen	Vercen	ú	HI 11	Name and Addre NES-RINA 800 New	LDI FÜNE Hampshir	e Ave, S	ilve	NC. er Sprin	g. MD 20904
			23a. Part1. Enter to shock, or hea	he disease, or comp trailure. List only	olications that caused one cause on each li	the death. Doi	not ente	er the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	•	Approximate Interval Between Onset and Death
E	Pnysician		Immediate Cause ( disease or condition resulting in death)	(Final on				to HEAC	)				
	/Medical Examiner		, , , , , , , , , , , , , , , , , , , ,	- 1	Due to (or as	a consequence	of):	suiciob)					
		Jer	Sequentially list con any, leading to in cause. Enter Under Cause (Disease or	nditions.	D	a consequence							
	ocuted nd transit	Examin	Cause (Disease or that initiated events resulting in death)	6	c								
,09	flicate be executed g physician and as the burial-transit	al E)	researing in Godding is		. Due to (or as	a consequence	01);						
68760,	ificate g phys	edical			d								
.O. Box	The law requires that the death certifi ste has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2[ 9 ☐ Unknown	months? ☐ No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (s <i>pecify)</i>	/			23d. Date of deli Month	ivery Day Year
Δ.	quires that in signed by uld be deta	þ	Part II. Other signif	ficant conditions o	ontributing to death b	ut not resulting i	n the ur	nderlying cause giv	en in Part I.	23e. Did t			the cause of death?
of Vital Records,		Completed	L									prior to death?	topsy findings available completion of cause of
Vita	ilcien: T certifica rector, p	Be	25. Was case refer examiner?		Hospital:			Oth		ath (Check only o			
of	Physical direction	T.	Yes 2□ 27. Manner of Deat		28a. Date of Inju	ry 28b.	tpatien Time of	28c. Injur	y at	Home 5 Z Hesi 28d. Describe			cify)
ion	nding I ath. r: After e funer	ation	1 □ Natural 2 □ Accident	5 Pending investigation	Month, Da		Injury	Wor	k? Yes 2 No	SHOT SOUF :	on Appl	ΧD	
Division	Hospitel or Attending Physicien: 44 hours after death. Funerel Director: After this certification by the funeral director,	Certification;	3 Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj building, et	ury - At home, fac. (Specify)	arm, str	eet, factory, office		City or To	em Ctata	RC., Silver	Shun IVO
	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai	29a. Certifier (Check only one)		ysicien: To the best niner: On the basis o and manner st	f examination an		restigation, in my o	pinion, death occ		date and	place, and due	to the cause(s)
)	To the Vithin 2 To the complet	Σ	29b. Signalure and	title of certifier	_no (	OME)		29c. Licens	a number			te signed (Month	
	10		30. Name and addr	ress of person who	completed cause of c	leath (Item 23a) 5 Rockw	(Type,	Print) Po	CKUILLE M	o rosor			
	Sta Registi		31. Date filed (Mon	ith, Day, Year)	32 Registr	ar's Signature		Sports	/				

State of Maryland / Department of Health and Mental Hygiene 00 1 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mildred Hi11 November 14, 2004 12:10a /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) **Examiner** Hillhaven Healthcare Adelphi Prince Georges If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 97 Yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2504F Yrs. 035050570 Director Sept. 27,1907 Rhode Island Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once. 1 ☐ Yes 2 ☐ No Directo Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10126 Renfrew Road 20901 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James L. Hill Ellen M. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles B. Simpson / Trustee 12501 Old Columbia Pike Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □Donation 5 □ Other (Specify) Parklawn Mem Park 11/22/2004 Rockville, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) UFOSEPSIS **Physician** 4 DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 2 Fetal death Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed LY BERTENSINE CARDIOVASCULAR DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3□ DDA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 2 ☐ Accident 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tyle NOVEMBER 15. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Mosth

CHARLES

10801 LOCKWOOD DRIVE # 205 SILVER STRING 20101 M. BENNER, MD 32. Pegistrar's Signature bouks

Physician	Decedent's Name (First, Middle, La.	•	erincate or	Deamtas	2. Dete of Dee Month	Reg. No. eth Dey	3.	Time of Death
/Medical	0001111	HELFAND		45 City Town or L	NOV.	21, 20	04	0249 AN
Examiner				4b. City, Town, or Lo CHEVERL				
	PRINCE GEORGES : 5. Social Security Number 6. S		(av) If Under 1 Year	If Under 24 Hrs.		PRI	NCE GEO	
Funeral Director		DXM 2□ F 28 Yrs	Months Devs	Hours Min.	8. Date of Birt (Month, Da) Jan • 6	1976	Wash.	(State or Foreign
×	Usuel Residence of Decedent	20						
show	10a. State 10b. County	10c. City, Town or						nside City Limits
e Ma	MD Prince	Georges Berwy	n Height	.S				XYes 2 □ No
Vih t	10e. Street end Number 5811 Swarthmo:	ro Drivo	10f. Zip Code	740		10g. Citizen of 1		
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15-0020 n 72 hours after death with the Maryle "natural", or Rema 23s or 28s-4 sho adical Examiner must be notified at lefted by Funeral Director	11. Maritel Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2X No	Specify:	Rican, etc.)		ck, White, etc.	
	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	ecedent's Usual Occup live kind of work done le. DO NOT use retired	durina most of work.	ing		usiness/Industry ersity yland	of
d 2 Hilled A	17. Father's Name (First, Middle, Last)		Student	18. Mother's Name	e (First, Middle,	Maiden Surnan	ne)	
Baltimore, Maryland 212 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than mary Injury or other traumatic event, the Monce.		Helfand	eiling Address (Street	Clar		Ander		al .
Ma d 2 s th an trau	Richard Helfan		23 Sea Hu					
re, Heal Heal tem 2	20a. Method of Disposition	The Company of the Co	sposition (Name of crematory or other place		Date		City or Town,	
Pages nant of intry or o	1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5)	Hemoval from State	Inrl Svcs	1	1/27/0	4 Alex	andria	, VA
Baltimore, permit. Pages 1 ar Department of Heal moortant: if Item 2 any Injury or other	21. Signature of Funeral Service Licer		22. Name and Addres	ss of Facility Sn	owden :	Funera	1 Home	P.A.
Bal pemil Depa Impo Impo	a good.	Sumelis	246 N Wa	shingto	n St R	ockvil	le, MI	20850
ESTEDEN!	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. To not	enter the mode of dyin	g, such as cardiac	or respiratory are	rest,	App	roximate val Between
, Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Multiple injurie  Due to (or as a con					Ons	et and Death
i ii g		b.————————————————————————————————————					1	
68760, ficate be executed physician and as the burial-transit edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Due to (or as a con-	sequence of):					
(0) ≝ ≝ ∞ (0)		Due to (or as e cons	sequence of):					
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P.O. that the ded by the datached	Part II. Other significant conditions of	ontributing to death but not resulting in the	e underlying cause giv	en in Paπ i.		obacco usa con ′es 2□ No		4 Unknown
Division of Vital Records, P.O. Box 6 or Attending Physician: The law requires that the death certific after death.  Director: After this certificate has been signed by the attending is in by the funeral director, page 2 should be datached for use as ertification: To Be Completed by Physician/Me					24a. Was a perform		available	utopsy findings e prior to ion of cause ?
Receive he law he law age 2 age 2					104	es 2□No	125Ves	
Vital Ricelan: The I	25. Was case referred to medical	-		26. Place of Death	(Check only or			
Vision of Vita Attending Physician: redeath recent recent the time certific by the funeral director, lifeation: To Be (	examiner? 1⊟Yes 2□ No	Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpat	tient 3 DOA Oth				er (Specify)	
ding Phy After thi funeral	27. Manner of Deeth  1  Natural 5 Pending	28a. Date of Injury 28b. Time 11-(21-04) 22:15	e of 28c. Injury Work	/ at k?	28d. Describe h			n from
sion aath. be fur he fur	2 Accident investigation	found found	M 1□	Yes 2X No	arking -	garage	uňkn	OWII
or Ath after d Direct in by 1	3 Suicide 6 XCould not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Numb n, State) $202$	Regent	s Drive
Urs af of the lifted in the li		parking garage		,C	ollege	Park, M	aryland	
Division C be Hospital or Attending P in 24 hours after death be Funeral Director: After it pletely filled in by the funera edical Certification:	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicai Exam	ysician: To the best of my knowledge, de ilner: On the basis of examination end/or	eeth occurred at the tim r investigation, in my op	ne, date end place, o pinion, death occurr	end due to the c ed at the time, d	ause(s) and ma late end place, a	anner es stated. and due to the	cause(s)
Divisio To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fi	29b. Signature end title of certifier	and manner stated.	29c. License	e number	2	29d. Date signe	d (Month, Day,	Year)
F N F S	1	U 16 0		C.M.E		NOV.	21, 20	
-	30 Name and address of person who	completed cause of geath (Item 23e) (Typ	oe. Print)					
	THE WORE MI	1. 0	enn Street,	Daltimos	n Mare	rland 21	1201	
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	am Street	DOLLINO	e, mary	المالات كا	LCVI	
Registrar	NOV 2 9 2004	De eva &	Docks					

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RPD			1 - For State Registrar		of Maryla	-	artment o		lealth and <i>Death</i>		Reg. Né	2001.	38175
	Physici	an	1. Decedent's Name (First, Midd Yvonne Elizal	-,,	hinson					2. Date of I Month NOVEN		10, 2004	3. Time of Death 10:17 pm
	/Medic Examir		4a. Facility Name (If not institution Route 231 @ Or	n, give street and r	number)		4b. City, To Hugh		r Location of Dea		40	County of Death	<u> </u>
	Funeral Director		5. Social Security Number 220–58–6067	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Months C	Year Days	If Under 24 Hr Hours Mir		Birth Day, Year)	9. Birth Cou	place (State or Foreign intry) ington, D.C.
	tryland show		Usual Residence of Decedent  10a. State 10b. County	1	10c. C	City, Town or Lo	ocation						10d. Inside City Limits
	the Mi	Funeral Director	MD Calve:	rt County	P	rince I	rederi				10g Cit	tizen of What Cou	1 ☐ Yes 2 X No
	3e or	Di	4805 Egret Cou	rt			206					S.A.	
	r death	iner	11. Marital Status	12. Was De	ecedent Ever in Forces?	U.S. 13.	Was Deceden	nt of Hi	ispanic Origin? ( an, Mexican, Pue	Specify Yes or I	No-	14. Race - Amer Black, White	
9036	ours after death with the Marylan trel', or tems 23e or 28e-1 show Exame set must be confined at	by	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce				1□Yes 2Ū	XNo	Specify:			Specify: Wh:	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23e or 28e-1 show eumatic event. The Madical Examination is marked other the material contents.	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed	d) (1-4or 5+)	16a. Dece (Give life. Sal		Occupa done d retired	ation during most of w f)	orking		ind of Business/II miture (	
and 2	d be filed antal Hygid ted other c event.	To Be Co	17. Father's Name (First, Middle Robert Daniel			, Sul	.00		18. Mother's Na Ana Vi	ame (First, Midd			Miparry
ary	d 2 should th and Mer 7 Is marke treumatic	۴	19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address (S	Street a	and Number or F	Rural Route Nun	ber, City o	or Town, State, Zi	p Code)
	and sealth m 27		William F. Hun  20a. Method of Disposition  1 🖁 Burial 2 □ Cremation	3 □Removal fro	m State 20b.	Place of Dispo cemetery, crea	osition (Name matory or othe	of er plac	Nov	ember 1	5, <sup>20c. Le</sup>	ocation - City or T	own, State
Baltimore,	permit. Pages 1 Department of F Importent: If ite any injury or ot		'4 □ Donation 5 □ Other (	Specify)	50		2. Name and	Addres	ss of Facility ${ m Le}$		al Ho		ert, P.A. MD 20736
•	Physician /Medical Examiner		23a. Parf1. Enter the disease. shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause or a. MU	t caused the den each line.	E IN			g, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
xecuted and Il-transit	Il-transit xaminer	Sequentially list conditions, if any, leading to immediate cause. Ent. of Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):											
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P.O. Box 6	hat the death certif d by the attending detached for use a	completely filled in by the funeral director, page 2 should be detached for use as the bu  Medical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1. Ves 2 No 9 Unknown	1 Live	outcome of preg e birth 2 Te gnant at time of known	tal death 3	□Ectopic preg □ Other (spec					23d. Date of deliv Month	rery Day Year
			Part II. Other significant condit	ions contributing to	death but not re	esulting in the u	nderlying cau	ise give	en in Part I.			. /	the cause of death?
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Division of Vital Records,			25. Was case referred to medic	al					26. Place of D	ath (Check onl		Yes	2□ No
			examiner? 1 X Yes 2 ☐ No			ER/Outpatie		-	4 🗀 Ruising			6XOther (Speci	(y) At Scene
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Divisio	of or Attence after death		3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number)								al Route Number,		
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	thin 2 the to the to	Med	29b. Signature and title of certifi	and m	anner stated.				e number			te signed (Month,	
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	5		30. Name and address of person		ause of death (Its			St	reet, B	altimor	e, Ma	ryland 2	1201
1	Sta Regist		31. Date filed (Month, Day, Year	32	Registrate Sig	nature La B	Born	R.O.	,				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Margaret E. Harris November 18, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg Village Nursing Care Center Frostburg If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 20X F Yrs. **Director** West Virginia 212-38-5546 96 10-Jun-1908 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show ral', or items 23a or 28e-f shov Examiner must be notified at Director 1 Yes 2 □ No Maryland Allegany Frostburg 10e. Street and Number 71 E. Mechanic Street 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No ð 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Homemaker other permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be ဥ Salvatore Mele Rosina Ruffo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Albert Avenue Francis Eugene Harris 21532-Frostburg Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removat from State 20-Nov-2004 Frostburg Saint Michael's Cemetery Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licer 22. Name and Address of Facility ohn Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** Myo Cardia /Medical Due to (or as a consequence of Examiner oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date ot delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part It. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Forilere 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy tindings available prior to completion of cause of death? page 2 autopsy performed ld age certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 ☐ Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of tnjury - At home, tarm, street, factory, office building, etc. (Specify) 4 \ Homicide Hospital 1 W Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel To the ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 Sandhir 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State of Mary		partment of F ertificate of			giene 004	38177		
	Physici		1. Decedent's Name (First, Middle, Last) EVELYN L. HUPP				2. Date of Dea Month	th Day Yea	3. Time of Death		
	/Medic Examin		4 T M 0 M E	n yrs. last birthda <b>Q7</b> Yrs.	Cun	r Location of Death  Out Out  If Under 24 Hrs.  Hours Min.	8. Date of Birth	4c. County of De	irthplace (State or Foreign Country)		
	Director		Usual Residence of Decedent	87 Yrs.  Oc. City, Town or	Location		DEC. 5,:	1916 WES	T VIRGINIA  10d. Inside City Limits		
	e Marylis la-f sho	ctor	MD ALLEGANY	CUMBERL					1X Yes 2 No		
đ đ	with the	i Director	10e. Street and Number   10f. Zip Code   10g. Cir   225   COLUMBIA STREET   21502   U.							Country?	
36	rs after death I', or itams 23	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Yes 2 No  1 □ Yes 2 No  1 □ Yes 2 No  1 □ Yes 2 No  1 □ Yes 2 No  1 □ Yes 2 No  1 □ Yes 2 No  1 □ Yes 2 No  1 □ Yes 2 No	r in U.S. 13	3. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, hite, etc.		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than *natural', or Itams 23a or 28a-f show appringnty or other traumatic event. The Medical Exactificat must be notified at ADDE.	Completed b	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12	(Gi	cedent's Usual Occup ve kind of work done DO NOT use retired	during most of work	ing	16b. Kind of Busines			
Maryland 2 nd 2 should be filed the and Mental Hyo	ld be filed ental Hyg ked other ic event, I	To Be C	17. Father's Name (First, Middle, Last)  COLUMBUS JACKSON FLEEK			18. Mother's Nam		Maiden Sumame)			
	12 shoul h and M 7 is mari traumati		19a. Informant's Name/Relationship (Type, Print) SHIRLEY J. McINTOSH / DAUGHT				al Route Number	City or Town, State			
	ages 1 and of Healt of Healt: If item 2.		20a. Method of Disposition 3 Removal from State	20b. Place of Dis	position (Name of rematory or other place	ce)	Date	20c. Location - City of			
Baltimore,	permit. P. Departme important any injury once.		'4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licen ee	TILLCRES	T MEML. PA <sup>2</sup> UPCHURCH 202 GREEN		HOME, P.	A.	21502		
	Physician /Medical Examiner	91	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fam. Healthough the immediate by the conditions.	YOCAYO	enter the mode of dyin		or respiratory arre		Approximate Interval Between Onset and Death INLEK		
8760,	18760, icate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, hadding to him collate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.								
I Records, P.O. Box 6 The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of p		23d. Date of delivery Month Day Year							
rds, P.	quires that in signed I uld be det	To Be Completed by	Part II. Other significant conditions contributing to death but no Diabetes Mellitus	23e. Did tobacco use contribute to the cause of death?  1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown							
Il Records, The law requires that has been signe	sician: The law re certificate has bee irector, page 2 sho						24a. Was a autops perform	y prior to ned? death?	autopsy findings available completion of cause of s 2 No		
Vital	ysician is certifi director		25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient	2 ER/Outpati	ent 3 DOA Oth	26. Place of Deat	The state of the s	e) ence 6 □Other (Sp	acify)		
Division of	ding Ph .r After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Ye	28b. Time	of 28c. Injury	y at		w injury occurred	os.iy,		
Division all or Attences after death i Director: d in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (S	reet and Number or F I, State)	Rural Route Number,							
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medicai (	29a. Certifier (Check only one)  1 ☑ Certifying Physician: To the best of m 2 ☐ Medical Examiner: On the basis of examiner stated.	amination and/or	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occurr	and due to the cared at the time, da	ause(s) and manner a ate and place, and du	is stated. le to the cause(s)		
ı	To 1 with To 1	Σ	29b. Signature and title of certifie		29c. Licens	9 number		9d. Date signed (Mor			
	52		30. Name and address of person who completed cause of death	1 (Item 23a) (Typ		>> 280		Jov 19,			
	Sta	te	Suni Guota, M.D. 63 31. Date filed (Month, Day, Year) 32. Registrar's	75 Ker	nt Aven	ll	Cumbe	erland,	MD 21502		
	Registr	1.00	NOV 2 2 2004 Bens	was 1	9 Anno	61					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State 11-18-04 Registrar Amend #23a.Prt.1.Per Phys. PGC cr Certificate of Death Reg. No. UUL 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 7:36 PM Carlon, Johnson NOV 2004 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death University of Maryland Hospital Baltimore, MD Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 1,1931 Birthplace (State or Foreign Country) 1 ₹M 2 ☐ F 73 473-30-9079 Yrs. Minnesota Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □XYes 2 □ No Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15716 Pointer Ridge Drive 20716 USA 12. Was Decedent Ever in U.S. Amed Forces? 1 ™ Yes 2 □ No If Yes, Give Year or Dates: 1951–59 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Dept. of Labor Elementary/Secondary (0-12) College (1-4or 5+) Management U.S. Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Arthur Johnson Hilda Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian A. Johnson / Son 232 Bowling Farm Ct. Raleigh, NC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11-17-2004 Alexandria, VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licens 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ischemia bowel disease or condition resulting in death) Due to (or as a consequence of): sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): aspiration Pheumonia that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 204 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical **Examiner** physician and s the burial-transit the Hospital or Attanding Physician: The law requires that the death certificate be executed Box 68760. P.O.

Jas

s after decreal Diractor: Att

within 24 hours a
To the Funeral C

Medical

Records,

Division of Vital

**Physician** 

/Medical

**Examiner** 

Funeral

Director

r Itams 23a or 28a-f show ther mast be notified at

permil. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itan any injury or other traumatic avant, the Medical Enai in Mone.

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

Physiclan/Medical Examiner þ Be Completed 2 1 ☐ Yes 2 💢 No 27. Manner of Death Certification:

25. Was case referred to medical Natural Accident

5 Pending investigation 6 Could not be determined

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 🗌 Suicide

4 Homicide

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AU 4176 435 LISZII 22 Greene St, Baltimore MD 21201

State Registrar 31. Date filed (Month, Day, Year) NOV 1 8 2004

Lee



		State of State of State of Registrar	Ce	rtificate of De	eath cas	Reg. No. 2004 38 79					
Physic		1. Decedent's Name (First, Middle, Last)			2. Date of Month	Death 3. Time of Death					
Physic /Medi		David Wayne	Jones			4BER 26, 2004 8:12p M					
Exami		4a. Facility Name (If not institution, give street and num	iber)	4b. City, Town, or Loc		4c. County of Death					
		25864 RICKEY DRIVE		HOLLYWOOD		SAINT MARY's					
Funeral		1 ■ M 2 □ F	<ol> <li>Age (In yrs. last birthday)</li> <li>Yrs.</li> </ol>			Birth 9. Birthplace (State or Foreign Country)					
Director		558-25-3556 Usual Residence of Decedent	38 Yrs.		Dec.3	, 1965   California					
land w		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits					
Mary	ō	Maryland St. Mary's		Hollywoo	1	1 ☐ Yes 2 € No					
the Marylan r 28a-f ehow	Director	Maryland St. Mary's  10e. Street and Number	10g. Citizen of What Country?								
with 3a or	D	2506/ Dist D		10f. Zip Code	0636						
hours after death with the Maryland hours after death with the Maryland turel; or Items 23a or 28a-f show at Examinat per redtified at	Funeral		dent Ever in U.S. 13.		inic Origin? (Specify Yes or Mexican, Puerto Rican, etc.)	United States No- 14 Race - American Indian,					
or Ite	Fur	1 Never Married 2 Married 1  Yes	2 □ No								
ours a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Given Year or Date of the Property of the Pr	e ites:	1 ☐ Yes 2 █ No S	pecify:	Specify: White					
be filed within 72 hours af tal Hygiene. Ind other then "natural", or event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	n most of working	16b. Kind of Business/Industry					
within ene.	npie	Elementary/Secondary (0-12) College (1	-4or 5+)	kind of work done durir DO NOT use retired)	ig most of working						
	Son	3	Resp	iratory The	erapist	U.S. Government					
Maryland of 2 should be file the and Mental Hy 27 is marked oth	Be	17. Father's Name (First, Middle, Last)		18.	Mother's Name (First, Midd	dle, Maiden Sumame)					
ylan	2	Charles Ray Jones			Wanda Fa	y Anthony					
IC, INCAT YIATI 1 and 2 should be 1 Health and Mental 1tem 27 is marked of		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and	Number or Rural Route Num	nber, City or Town, State, Zip Code)					
	Н	Rhonda E. Jones / Wife				, Maryland 20636					
00-	3	20a. Method of Disposition 1 ☐ Burial 2  Cremation 3 ☐ Removal from 9	20b. Place of Dispo cemetery, crer	osition (Name of matory or other place)	Date	20c. Location - City or Town, State					
Dattillore; permit. Pages 1 al Department of Hea Importent: If Item any injury or othe once.		`4 □Donation 5 □ Other (Specify)	Brinsfiel	d-Echols	11-30-2004	Charlotte Hall, Maryla					
permit. Departi		21. Signalur of Funeral Servic - idensee	22	2. Name and Address of		ld Funeral Home, P.A.					
0 89E 89			M01114 22	955 Hollywo	od Road, Leon	nardtown, MD 20650-0279					
		23a. Part1. Enter the disease, or confiling tions that ca shock, or heart failure. List only one cause on ea	lused the death. Do not ent	er the mode of dying, s	uch as cardiac or respiratory	v arrest, Approximate Interval Between					
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at the ded by the a	hy	9 Unknown									
L 2 73	by	Part II. Other significant conditions contributing to de				d tobacco use contribute to the cause of death?					
law requires tas been signed as should be o	ted	HYPERTENSIVE ATHEROSCLERO	IIC CAKDIOVAS	SCOPAK DISE	ASE	Yes 2 No 3 Probably 4 Unknown					
law law as b	E	DIABETES MELLITUS			24a. Wt	topsy prior to completion of cause of					
_ € e S		EARLY CIRRHOSIS			1 Yes	rformed?   death?					
ysicien: The ysicien: The ysicient of ysic	Be (	25. Was case referred to medical examiner?		26	Place of Death (Check only	у опе)					
Physicien: this certific ral director,	2	Hospital:	patient 2 ER/Outpatien	nt 3 DOA Other:	1 ☐ Nursing Home 5 ☐ Re	sidence 6 the (Specify) SCENE					
lor Attending Physicien: 1 after death. Director: After this certificat in by the funeral director, p.	Certification:	27. Manner of Death 1 ▼Natural 5 □ Pending (Month	e how injury occurred								
Attending r death. actor: After oy the fune		2 Accident investigation	2 No								
or At ifter d Direct in by		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildin	28f. Location City or 7	cation (Street and Number or Rural Route Number, y or Town, State)							
is af											
Hospitel A hours a	edical	29a. Certifier  (Check only  1 ☐ Certifying Physician: To the 2 ☑ Medicel Examiner: On the ba	best of my knowledge, death sis of examination and/or in	n occurred at the time, divestigation, in my opinic	late and place, and due to the	le cause(s) and manner as stated. e, date and place, and due to the cause(s)					
To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medi	one) = and mann	er stated.								
5 wit 5	~	29b. Signature and title of certifier		29c. License nu	mper	29d. Date signed (Month, Day, Year)					
F > F 0		1/1/20	)	OCME		NOVEMBER 27, 2004					
		30. Name and address of person who completed cause		·							
F > F 0		many G. RIPPL	111	PENN STREE	T, BALTIMORE,	MARYLAND 21201					
Sta Regist		many G. RIPPL	111	·	T, BALTIMORE,	MARYLAND 21201					

State of Maryland / Department of Health and Mental Hygiene 0 4

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death 3. Time of Death NOV 14, 2004 **Physician** Letitia Jarrett 12:34 PM /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.
April 5, I Prince George's Hospital Center Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ XF Yrs. 078-48-7445 92 Director 1912 Jamaica Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or itema 23a or 28a-f shor other treumatic event, the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6206 60th Avenue 20737 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 2 No Specify: 2 SpecifyWest Indian 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other eny injury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Lewis Roseann Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edburn Jarrett/Son 6206 60th Avenue, Riverdale MD 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery 11/21/04 Adelphi, MD 22. Name and Address of Facility of Funeral Service License Latimore Funeral Services, P.A. 6906 Kent Town Drive, Landover MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary arrest **Examiner** Due to (or as a consequence of): Examiner Multi organ failure The law requires that the death certificate be executed attending physician and for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Atherosclerotic cardiovascular disease Box 68760 Physician/Medical Due to (or as a consequence of): Division of Vital Records, P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Ď 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 212 No 1 ☐ Yes 1 □ Yes 2 □ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide Mospital 24 hours a Funeral C 102 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plane, and due to the nause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 22a Cirtifier and manner stated To the within 2 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) MD21102 November 15, 2004 ame and edds-ss of person who completed cause of death (Item 23a) (Type, Print) Norman Allen, MD 1647 Benning Road, N.E. #201, Washington DC 20002 31. Date filed (Month, Day, Year) State NOV 1 8 2004 Registrar

DHMH 16 Rev 6/95

00		State Registrar  Decedent's Name (First, Middle, I	Last)		Certificate of	Dealii	2. Date of Dea		114	3. Time of Death
Physician /Medical		PATRICIA ANN	<b>JAFFRAY</b>				Month -	Day 12-	Year 154	6145a
Examiner		la. Facility Name (If not institution, g	give street and number)	,		or Location of Death	1		y of Death	
		Franklin Square 5. Social Security Number 6		of (In yrs. last birt.	Rused	ale r   If Under 24 Hrs.	P. Data of Birth	Balt	more	(C)
Funeral Director		222-44-4325	. Sex / 7. Age		Yrs. Months Days		8. Date of Birth (Month, Day JAN 19	1956	9. Birthpia Count DOVER	ace (State or Fore try) DELAWAR
	Ţ	Usual Residence of Decedent					ļ			
work		10a. State 10b. County		10c. City, Town					10	od. Inside City Lim 1 ☐ Yes 2 🛣
to r 28a-f show	ec10	MD HOWARD  10e, Street and Number		COLUI				10- 0::	14.0	
la or	בַ	9400 RIVERARK	RD.		10f. Zip Code <b>21</b> (			10g. Citizen of USA	what Count	uy?
ritems 23s	lera -	11. Marital Status	12. Was Decedent E	Ever in U.S.	13. Was Decedent of If Yes, specify Cu		pecify Yes or No-		ice - America	
or ite	2	1X Never Married 2☐ Married	Armed Forces?  1 □ Yes 2 K N	10	1 ☐ Yes 2X No		o Hican, etc.)	Speci	ack, White, e	
ural,	<u> </u>	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1					<u></u>	
"nat	Completed	15. Decedent's (Specify only highest)	grade completed)	16a.	Decedent's Usual Occi (Give kind of work don- life. DO NOT use retir	upation e <i>during most of won</i> red)	king	16b. Kind of E	Business/Indi	ustry
Ire N	E	Elementary/Secondary (0-12)	College (1-4or 5-	+)	HN HOPKINS			US	GOVERN	NMENT
d othe event,	Se .	17. Father's Name (First, Middle, La	ist)			18. Mother's Nam	ne (First, Middle,	Maiden Suma	me)	
arked arice	0	CLIFORD W. JAFF	RAY			JUNE MA	UREEN UI	JSH		
Department of Health and Mental rygelee. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. If a Madical Evaninet must be notified at once.  To Re Commissed by Firmeral Director		19a. Informant's Name/Relationship ANN WALSH -FRIE			Mailing Address (Stree					Code)
item 2	2	20a. Method of Disposition		20b. Place of	Disposition (Name of y, crematory or other pi	lace)	Date	20c. Location	- City or Tov	wn, State
A S E		1 ☐ Burial 2 Cremation 3  '4 ☐ Donation 5 ☐ Other (Spe			RN VA CREMA		6/04	ARLING	TON, VA	A
ppartin porta ny inju		21. Signature of Funeral Service Lic	censee / /			ress of Facility <b>ARI</b>				
2 = 2 2	_	Mary	alden	,	3901 N. FA					
		23a. Part1. Enter the disease, or co	omplications that caused							
			nly one cause on each lin	the death. Do n ie.	not enter the mode of dy	ying, such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Death
		snock, or near tailing. List or Immediate Cause (Final disease or condition resulting in death)	_a Pulmon	ian E	mbolism	ying, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
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			1 - For State Registrar	State of N	Marylar			of Hea	alth and	Mental Hy		004	38182
	Physicia	an	1. Decedent's Name (First, Middle	, Last)						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Han Young Ka				4h Cihi Ta		antian of Dan	Novemb	-	2004	4:15 A M
	Examin	er	4801 Willes Vis		")		Boy		cation of Dea	ın		nce Geo	rges
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs.	last birthday,	If Under 1	Year If	Under 24 Hrs	s. 8. Date of Bir		9. Birtho	place (State or Foreign
	Director		214-06-7803	1XM 2□F	7	6 Yrs.	Months [	Days H	lours Min	8. Date of Bir Month, Da Nov. I c	1927	Seou	il, Korea
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or L	ocation						0d. Inside City Limits
	Maryl -f sho	tor	MD Prince	Georges		Bladen	sburg						1 <b>X</b> Yes 2 □ No
	r 28a	Funeral Director	10e. Street and Number				10f. Zip C	ode			10g. Citizer	of What Cour	ntry?
	th wit	al D	5999 Emerson S	treet APT	#623		20	710			U	SA	
	r dea	uner	11. Marital Status	12. Was Deceder Armed Force	s?	I.S. 13.	Was Deceder If Yes, specify	t of Hispai Cuban, M	nic Origin? ( lexican, Pue	Specify Yes or No rto Rican, etc.)	- 14.	Race - Americ Black, White,	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ed 1 Yes 2 If Yes, Give Year or Date:			1 ☐ Yes 2 ∑	No S	pecify:		Sp	ecity: Kon	ean
9	2 hou	ted	15. Decedent	's Education		16a. Dece	dent's Usual C	Occupation	1		16b. Kind	of Business/In	dustry
215	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Modical Examiner must be mullified at	Completed	(Specify only highes Elementary/Secondary (0-12) 12	College (1-4c	or 5+)	life.	kind of work of DO NOT use	done durin retired)	ng most of wo	orking			
121	be filed within 72 hours after death with the Marylar Ital Hygiene. In the manual, or Itams 23a or 28a-f show other than "natural", or Itams 23a or 28a-f show avent. It e Medical Examirer must be notified at			( )-1)				40		(F:			
and	ould be fi Mental H tarked otl	Ве	17. Father's Name (First, Middle,	Last)				18.		me <i>(First, Middl</i> e, Z. Park	Maiden Su	mame)	
Maryland 21215-0036	E D F F	To	Dae Y. Kang  19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address (S	itreet and I		ural Route Numbe	er, City or To	own, State, Zip	Code)
	nd 2 lith a 27 is r tra		Mary Nam/ Daugh	iter			_			tchellvi	-		
ore,	of Head of Item		20a. Method of Disposition  1 X Burial 2 ☐ Cremation	2 Pomovel from Ste	.   4	cemetery, cre	osition (Name matory or othe	r place)		Date		ion - City or To	
Ĕ	Pages ment of ant: If It ury or o		'4 □ Donation 5 □ Other (S		La	kemont Gard	Memori ens	lal		14/2004			.11e, MD
Baltimore,	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service	Licensee		2	2. Name and A	Address of Annap	Facility Ro	bert E. load Bow	Evans vie, M	Funera D 2071	1 Home .5
Ι.			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	ed the dear	th. Do not en	ter the mode o	of dying, su	uch as cardia	ic or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		-	Cance	r						15 months
	Examiner			Due to (or a	as a consec	quence of):							
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	cuted nd ransit	Examiner	cause. Enter Underlying that initiated events	c									
30,	be executed sician and burial-transit	i Ex	resulting in death) Last	Due to (or a	as a consec	quence of):							
68760,	cate b physic s the b	dicai		d									
Box 6	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon							23d	Date of delive	erv
	death e atte ed for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth	at time of o		∃Ectopic pregi ∃ Other <i>(speci</i>					Month	Day Year
P.0	The law requires that the de ate has been signed by the a page 2 should be detached	hys	9 Unknown	9□ Unknown							UIL I		
Ś	res that	by	Part II. Other significant condition	ns contributing to death	but not res	sulting in the u	inderlying cau:	se given in	Part I.				e cause of death? ably 4 □Unknown
Orc	w requir been sl	eted								12			
Record	The law ate has b	ompieted								24a. Was autor perfo		4b. Were auto prior to cor death?	psy findings available apletion of cause of
		e Co	25. Was case referred to medical					26	Place of De	1 ☐ Yes	2 X No	1 🗆 Yes	2 XNo
of Vital	ysic is ce direc	To B	examiner? 1 □ Yes □ 2 🏋 No	Hospital: 1  Inpa	itient 2	ER/Outpatie	nt 3 DOA					Other (Specify	Sons Home
	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pendin	28a. Date of Ir (Month, L	njury Day Year)	28b. Time o	f 28c	Injury at Work?		28d. Describe I			
Sio	en eatl or:	catio	2 Accident investig	ation			М	1 🗌 Yes	2 No				
Division	l or Att after d Diract J in by I	Certification	4 Homicide determ	288. Place of	Injury - At h etc. <i>(Speci</i>	ome, farm, st fy)	reet, factory, o	ffice		City or Tox	street and N vn, State)	umber or Rura	l Route Number,
	spital		29a. Certifier 1 X Certifyin	g Physicien: To the be	st of my kne	owledge, deat	h occurred at t	the time, d	late and plac	e, and due to the	cause(s) and	manner as st	ated.
	To the Hospital of within 24 hours at To the Funerel D completely filled it	Medical		Exeminer: On the basis and manner	of examina								
	To the within To the comp	×	29b. Signature and title of pertifier	11/	1	,		icense nur				gned (Month,	
)			Man	4 (1/6)			D	20352			Nove	mber 12	2, 2004
			30. Name and address of person Harvey I. Kap	who completed cause of Zen 8926 Wo				lint	on MT	20735-	4218		
	Sta	te	31. Date filed (Month, Day, Year)	32. <b>P</b>	strar's Signa		1/201		OII, FIL	, 20/33-	+210		
	Registr		NOV 1			K A	book						
	-												

/Medic Examin	an al	1. Decedent's Name (First, Middle, L	Lois	Virginia	Koontz		2. Date of Deat Month	Day Ye	3. Time of Dea	
		4a. Facility Name (If not institution, gi	ive street and number)			r Location of Death		4c. County of [		
		University of M 5. Social Security Mumber 6.			(3a) + i	more, P	LD	Battin		
Funeral Director		214-28-0472	Sex 7. Age	e (In yrs. last birthday) 73 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, May 31,		. Birthplace <i>(Stat</i> e or For Country) Maryland	eign
Mo #		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Lin	nits
e-f sh	tor	Maryland Fred	erick	Freder	ick				1 ☐ Yes 2 ☐	No
or 28 Ne Dot	Direc	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	at Country?	
s 23a	ral	500 D, Bradle			2170				States	
netural', or Itams 23a or 28e-f show deal Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☐ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give 2 Year or Dates:	10	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spe an, Mexican, Puerto i Specify:	cify Yes or No- Rican, etc.)	Black, V	American Indian, White, etc. White	
'netural', dical Exe		15. Decedent's I	Education	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busin		
W E B	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired	during most of workii 1)	ng			
		11. Father's Name (First, Middle, Las		5	Secretary	18. Mother's Name			Co. School	. Bd
d d o	o Be	Ralph	Monroe	Thomas		Lois	V.		ompher	
and Men Is marke eumatic	-	19a. Informant's Name/Relationship	(Type, Print)		ng Address (Street a	and Number or Rura				
f Health and Menitem 27 Is marke other treumatic		William R. Koon	tz / Husbar		D, Bradle	ey Ct./ Fr		Marylan	d 21703	
0		20a. Method of Disposition 1   Burial 2 □ Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, crei				Oc. Location - City		
		*4 ☐Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice							,Maryland	
Departr Importe any Inju		Baymond	Peters	on 10		umtown Pi	ke/ Fred	lerick, M	omes, P.A. MD 21702	
		23a. Part1. Extenthe disease, or conshock, or heart failure. List only	mplications that caused y one cause on each lin	the death. Do not ent le.	ter the mode of dying	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death	
rysician Medical		Immediate@ause (Final disease or condition resulting in death)	a. Mass	ire Hen	norrhag	e			Onsol and Dodin	
xaminer			Due to (or as:	a consequence of):	norrhag Cancer Ulcer	_				
	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):	Cuncer					
and transi	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Duoc	lenal	Ulcer				-	
nysician and he burial-transit	al E		Due to (or as a	a consequence or):						
hys	edical		d							
g p	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth		Ectopic pregnancy			23d. Date of		
tending pl	02		4□Pregnant at		Other (specify)			Month	Day Year	
attending p for use as	sicla	1 Yes 2 No	9□ Unknown							
by th	/ Physiclan/M		9□ Unknown	ut not resulting in the u		en in Part I.	23e. Did tob	acco use contribut	te to the cause of death?	
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N. A. Ranjithan, 517 Oldtown Road, Cumberland, Maryland 21502

31. Date filed (Month, Day, Year)

NOV 1 6 2004

32. Registrer's Signature

Spacks

DHMH 16 Rev 6/95

State Registrar

				artment of Health and Me	ental Hygien	2001 30102
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  Alice Arrington Keys  4a. Facility Name (If not institution, give street and number)		Jovembar	3. Time of Death 2004 3:35P. M.
	Funeral	iei	North Arundl Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Glen Burnie	Date of Birth	nne Arundel  9. Birthplace (State or Foreign Country)
	Director		213-24-0086		(Month, Day, Yea 6-5-193	10d. Inside City Limits
	th the Mary or 28a-1 shi	irector	MD Anne Arundel Glen Bu	10f. Zip Code	10g. C	1 Yes 2 □ No
336	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Iften 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event. The Madical Examinat roust be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 X No If Yes, Give Yes,	21060  Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Rid  □ Yes ※ No Specify:	fy Yes or No-	JSA  14. Race - American Indian, Black, White, etc.  Specify: White
121215-0036	2 should be filed within 72 hor and Mental Hygiene. Is marked other than "naturi aumatic event, the Medical E	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Giv.	dent's Usual Occupation skind of work done during most of working DO NOT use retired)  1001 COOK  18. Mother's Name (I	An	Kind of Business/Industry  nne Arundel Schoo
Maryland	2 should be f and Mental H is marked of aumatic eve	To Be	William L. Arrington	Vena Dok	oson	
	and 2 sho ealth and n 27 is m			ing Address (Street and Number or Rural F Dorchester Rd, (		
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.			osition (Name of matory or other place)  Cemetery 11-15		Location - City or Town, State St. Michaels, MD
Balt	permit. Pages Department of Important: if it any injury or o			2. Name and Address of Facility  R. Carroll Hurley  P.O. Box 518. St.		
	rnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (n as a consequence of):	ieftine finode of dying, such as fardiac or f	espitatory afrest,	Interval Between Onset and Death
8760,	rate be executed whysician and the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate out as the following that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical		□Ectopic pregnancy □ Other ( <i>specify</i> )		23d. Date of delivery Month Day Year
4	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Il Records,		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 \[ Yes \] 2 \[ No \]
Division of Vital	* Attending Physician: Ther death. rector: After this certificate by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner?  1	of 28c Injury at 28c Work?  M 1 Yes 2 No	5 ☐ Residence d. Describe how inju	6 □Other (Specify)  uny occurred  und Number or Rural Route Number,
Ö	Hospital or / 24 hours after Funeral Dire tely filled in b		4 Homicide building, etc. (Specify)		City or Town, Star	re)
	the the	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	evestigation, in my opinion, death occurred	at the time, date ar	nd place, and due to the cause(s)
	with To	-	29b. Signature and title of certifier	29c. License number D43977		ate signed (Month, Day, Year)  2004;
			30. Name and address of person who completed cause of death (Item 23a) (Type Complete Oxer umi. 30) Hospital D	Rive, Clen Burn	ie. Mu	D. 21061.
•	Sta Regista		31. Date filed (Month, Day, Year) 32. Registrare signature	d)		

			S					Health and			•	
			1 - State Registrar				tificate o			_	200	4 38181
п	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of De			3. Time of Death
	/Medic	al	ANNA G. KESSLER						NOVEMB	ER 9	, 2004	6:50 P M
	Examin	er	4a. Facility Name (If not institution, give streem MONTGOMERY GENERAL				OLNEY	, or Location of Dea	MA		County of Dea	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last b	oirthday)	If Under 1 Yes					rthplace (State or Foreign Jountry)
	Director		212-10-2700	2 <b>X</b> ) F	85	Yrs.	World Day	S Hours Will	SEPT.	21,	1919 PC	DLAND
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits
	Mary B-f sh	tor	MARYLAND MONTGOMERY		SILVE	R SPF	RING					1∭Yes 2 No
	ith the	Director	10e. Street and Number				10f. Zip Code	)		10g. Citi	zen of What C	ountry?
	sath w	erai	15115 INTERLACHEN I			12.14		906	C		S.A.	
·0	fter de r ftem uner	Funerai	1 Never Married 2 Married	Was Decedent Ev Armed Forces? 1 □Yes 2 X No				f Hispanic Origin? ( uban, Mexican, Pue	rto Rican, etc.)	)-	14. Race - Am Black, Whi	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show the Madical Examinar must be notified at	þ	3	If Yes, Give Year or Dates:		1	☐Yes 2ĂN	lo Specify:			Specify: W	HITE
5-0	"natu	Completed	15. Decedent's Education (Specify only highest grade co	on impleted)	168	(Give k	ent's Usual Occ and of work don	ne during most of we	orking	16b. Ki	nd of Business	/Industry
12	withir iene. than	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		OMEMA	ONOT use ret KER	rea)		OWN	HOME	
<u> </u>	il Hygi other	Be C	17. Father's Name (First, Middle, Last)		1110	JIILII.	IKLIK	18. Mother's Na	ame (First, Middle			
ylar	Ments Ments arkad	ToE	SOL GR	OSSFELD				EVA		F)	RIEDMAN	
Maryland	12 shoth and 7 is m		19a. Informant's Name/Relationship (Type,	•				et and Number or F			100	25
<u>6</u>	Healt Healt tem 2 other		NANCY K. SHENK/DAUG 20a. Method of Disposition	HTER	20b. Place	of Dispos	ition (Name of	DR., GA	ITHERSBU: Date		MD 2088 cation - City or	
OE	Pages nnt: If I		1 X Burial 2 ☐ Cremation 3 X Remi 3 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	1	•	atory or other p	GDNS. 11/	11/2004	FATT	S CHIIDO	TH WA
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show among injury per other traumatic event, the Madical Examinet must be notified at once.		21. Signature of Funeral Service Licensee	٠		22.	Name and Add	ress of Facility  GEL FUNER				on, va
ш	20529		Donald C. Y	Cottler	yer	· IIII9	I ROCK	JIII H PIK	E BUCKU	TTTT	, INC , MD 20	
Į.	Discolates		23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c Immediate Cause (Final							rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	EMORRHAG Due to (or as a				135	5 1			
П	Examiner		Sequentially list conditions. 5 I	NTRACRAN				Chie Olive	0/20			
	led sit	nine	Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	a of):	1/1	Clar Chre				
Ć.	icate be executed physician and s the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence	∋ of):						
1760,		cai	d									
x 68	that the death certifical ed by the attending ph detached for use as th	Physician/Med	IF FEMALE:						_			
Вох	attenc for us	cian	in the past 12 months?	If yes, outcome of 1□Live birth 2 4□Pregnant at tir	Fetal deat		Ectopic pregnar Other (specify)			2	3d. Date of de Month	livery Day Year
P.O.	t the d by the ached	hysi		9□ Unknown			out (speeny)					
	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as th	by P	Part II. Other significant conditions contrib	uting to death but	not resulting	in the und	derlying cause	given in Part I.	23e. Did to	obacco u	se contribute to	the cause of death?
ord	een si	ted	DIABETES MELLITUS						10,	Yes 2∭	ONo 3□Pi	robably 4 Unknown
Records,	has b	ompieted	HYPERTENSION						24a. Was autop	an osy rmed?	24b. Were at prior to death?	utopsy findings available completion of cause of
Vital		e Co	25. Was case referred to medical					OS Plans of Do	1 ☐ Yes	2X No		2 No
	d is	To B	examiner? 1 X Yes 2 No Hosp	oital: 1 💢 Inpatient	2 🗆 ER/O	outpatient	3□ DOA	Other: 4 Nursing			i □Other (Spe	cify)
Division of	tanding Ph leath. tor: After th the funeral	on:	27. Manner of Death  1 Natural 5 Pending	8a. Date of Injury (Month, Day		Time of Injury	28c. In W	ork?	28d. Describe I			
<u>s</u>		icati	2 Accident investigation 3 Suicide 6 Could not be	8e. Place of Injury	/ - At home f	farm strae		□Yes 2□No	28f Location /	Street and	Number or Ri	ural Route Number,
<u>&gt;</u>	el or A safter I Direction by	Certification:	4 Homicide determined	building, etc.	(Specify)	iaiii, stree	or, ractory, orne	6	City or Tov			arai Nodio Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direc completely filled in by	edical (	29a. Certifier (Check only 2 Medical Examiner:	an: To the best of	my knowledg	ge, death o	occurred at the	time, date and plac	e, and due to the	cause(s)	and manner as	s stated.
	the H	Medi	one) 29b. Signature and title of certifier	and manner state	d.			nse number			e signed (Mont	
	T W T		Dr. Liture Heins	_ П	P			58542		NOV		
	10		30. Name and address of person who complete							IN U V	10 7	2004
			LIBUSE HEINZ-MOMCIL			501	GEORGIA	AVENUE #	515, WHE	EATON	, MD 20	0902
	Sta Registr		31. Date filed (Month, Day, Year) <b>NOV 16</b> 2004	32. Registrar	-	B	Sport	ad				

			1 - For State Registrar	State of M	arylan		artment of I		Mental Hyg	jiene	2004	381	87
	Physici		1. Decedent's Name <i>(First, Middle, L</i> a Karen	<sub>st)</sub> Mar	·i o	K a	ine		2. Date of Dea Month Novemb	Day	7 2004	3. Time of 8:41	Death a <sup>M</sup>
	/Medi Examir		4a. Facility Name (If not institution, giv			ı\a		or Location of Dea			County of Death	0.41	a_
			6550 Academy Dri				Ox	vinas			Calver	<b>-</b>	
	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hr		Year)		lace (State of	r Foreign
	Director		218-58-1975	□M 2XIF	53	Yrs.	Wichins Days	TIOUIS WIII	July 11			yinia_	
	and **		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	ocation				1,	Od Incido Cit	hr Limito
	lanylishor	5			100.00	y, rount of Lo					1	0d. Inside Cit	
	28a-1	Director	MD Calve	ert			Ov 10f. Zip Code	vings		Oa Citie	en of What Cour		-A
	with							0506	'	og. Citize		ili y r	
	leath	Funeral	6550 Academy Dri	12. Was Deceden	t Ever in U	.S. 13.1		0736 dispanic Origin? (	Specify Yes or No-	14	USA 4. Race - Americ	an Indian	
10	r Iten	臣	1 ☐ Never Married 2 🔀 Married	Armed Forces	?		If Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		Black, White,		
8	el', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1⊡Yes 2 <mark>M</mark> No	Specify:		S	Specify: wh	ite	
21215-0036	n 72 hours after death with the Maryland "naturel", or Items 23e or 28s-1 show salcal Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation		16a. Dece	dent's Usual Occup	ation	orking	16b. Kind	d of Business/Inc	dustry	
7		nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retire	d)	Jiking				
21		Cor		4		acco	ountant	1		cre	dit unic	on	
pu	d d d	Be	17. Father's Name (First, Middle, Last)					18. Mother's Na	ime (First, Middle, I	Maiden S	iumame)		
<u>Y</u>		은	Robert L.		Wheat.			Marie				esson	
Maryland	C1 00 - 68		19a. Informant's Name/Relationship (						lural Route Number		Town, State, Zip	Code)	
	1 and Health 9m 27 ther tr		R. Brooke Kaine, 20a. Method of Disposition	husband	20h P	6550	Academy .	Drive, O	wings, MI		736		
ğ	m 0 .		1   Burial 2 □ Cremation 3 □		e c	emetery, cren	natory or other pla				ation - City or To		
Baltimore,	그 분 뿐 글		* 4 □ Donation 5 □ Other (Specif		St				-20-04	Princ	ce Frede	erick,	MD
Ba	Deparamental Depar		21. Signature of Funeral Service Licer	I See			2. Name and Addre						
			23a. Part1. Enter the disease, or com	nlications that cause	od the death				ome, P.A.		wings, N	Approximate	
No.	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	line.	tatic	Bred		ancel	/	n n	Interval Betw Onset and D	veen
	/Medical Examiner		resulting in south,	Due to (or a	s a consequ	uence of):							
		er	Sequentially list conditions,	b. Due to (or a	s à consecu	uence on:							
	nsit	m in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	, , , , , ,	,								
Ć.	exect n and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or a	s a consequ	uence of):							
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical		d									
9	tiffica ng ph as th	led											
Вох	leath certifica attending pt d for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnancy	,		23	d. Date of delive	*	
В	the at hed fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (specify)				Month	Day Y	ear
<u>Р</u>	by ac	Phy	9 Unknown						00 01111				
		by	Part II. Other significant conditions of	ontributing to death	but not rest	uiting in the ur	nderlying cause giv	en in Part I.			ontribute to the Solon		
0	law requires as been sign 2 should be	eted							1 1 16	s 260		abiy 4Oi	IKIIOWII
ec	e law has b	Completed							24a. Was ai autops	y	24b. Were autop prior to con	osy findings a npletion of ca	vailable use of
프	Th ate pag	S							perform 1 ☐ Yes 2		death?	2□ No	
Ž.	Phyeicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		ath Check onl one				
of		7.	1 ☐ Yes 2ÊNo  27. Manner of Death	1 L Inpat		ER/Outpatien 28b. Time of	I 3 DOA	4   Nursing	dome 5 Reside			)	
on	tending Ph Jeath. Ior: After th the funeral	tlon	Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ay Year)	Injury	Wor	k? Yes 2 □ No	Edd. Bodonbo no	w injury c	30001160		
Division of Vital Records,	l or Attending efter death. Director: Aftel in by the fune	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Ir	njury - At ho	ome, farm, stre	eet, factory, office		28f. Location (Str	eet and f	Number or Rural	Route Numb	er,
á	el or A s efter il Dire	Certification	4  Homicide determined	building, e	tc. (Specify	()			City or Town	, State)			
	To the Hospitel or At within 24 hours effer of To the Funeral Direct completely filled in by	edical (	29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner s	ot examinal	wledge, death tion and/or inv	occurred at the ting restigation, in my o	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, da	use(s) an	nd manner as sta lace, and due to	ated. the cause(s)	
	To the P within 24 To the F complete	Me	29b. Signature and title of certifier	11/11	1		29c. Licens	e number	29	d. Date s	signed (Month, L	Day, Year)	
	-		<b>)</b>	110			0	3317.3		11-	17-104	1	
	On I		30. Name and address of person who	completed cause of	death (Item	23a) (Type, I	Print)		1		112	1_	100
C	XU		Jonathan Lowenth	al, M.D.,	110	Hospit	al Rd., S	Ste. 310	Prince	Frede	eick, M	20678	3
	Sta Registr		31 Data filed (Month Day Year)	7 2004 N	ratte Signal	turo					- 000		
	riegisti	aı	1101 T	·	ACTIVE.	1 15	HOSKEL						

			1 - State Registrar  1. Decedent's Name (First, Middle, La.		Maryland	-	artment of tificate of		d Mental Hy	Reg. No. 20	
	Physici /Medic	cal	Grace Eleanor	Kyle	or)		4b_City_Town.	or Location of D	Nov. 1	.0 Day 2004	Year 3. Time of Death 0540 M
	Examir	ner	4a. Facility Name (If not institution, given Bonds Forest Assi				Finkson			4c County	
	Funeral Director		5. Social Security Number 212-24-1734 6. S	<sup>8X</sup> □ M 2 ️ F	Age (In yrs. Ia 77	Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bin (Month, Da October 2	th ly, Year) 22, 1927	Birthplace (State or Foreign Country)     Barton
	Maryland -f show	tor	10a. State 10b. County  Maryland Car	roll	10c. City	, Town or Lo	cation	Finksburg	3		10d. Inside City Limits 1
	3a or 28a	Funeral Director	10e. Street and Number 8 E Mayer Dr	ive Todd Vi	llage		10f. Zip Code	21048		10g. Citizen of W	Vhat Country? USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, it a M. cilcul Examitant must be notified an ance.	by Funera	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 🂢 Divorced	12. Was Deceder Armed Force 1  Yes 2 If Yes, Give Year or Dates	s? No		Was Decedent of f Yes, specify Cut		? (Specify Yes or No Puerto Rican, etc.)	- 14. Race Black Specify:	e - American Indian, k, White, etc. : White
Maryland 21215-0036	filed within 72 ho Hygisne. other than "natur ent, to M. alcall	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4c	or 5+)	16a. Deced (Give life. L	lent's Usual Occu kind of work done DO NOT use retire Lin	pation during most of ed) e Inspecto		16b. Kind of Bu	siness/Industry Paper Cup
/land	should be filed and Mental Hyg Is marked othe aumatic event,	To Be C	17. Father's Name (First, Middle, Last)	Thomas Me	tz			18. Mother's	Name (First, Middle, Ed	Maiden Sumame ith Dawson	<i>e)</i> I
	1 and 2 sho Health and I em 27 Is me ither traume		19a. Informant's Name/Relationship ( Cheryl Cecil-I			19b. Mailin	-		or Rural Route Number nor Drive, Fink		
altimore,	permit. Pages 1: Department of He Important: If iten any injury or oth		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification)		1 00	metery, cren	sition (Name of natory or other pla Hill Cemete		Date November 13, 2004		City or Town, State v Mills, Maryland
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service Licer	nsee			. Name and Addr ichhorn-McK	,	ral Home 8 Eas	t Main St., Lo	onaconing,Md. 21539
	Physician /Medical Examiner	ər	23a. Part.1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	a. Due to (or a	ised the death.  JLVA as a consequal	ence of):	CANC	_	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ						
.O. Box 6	The law requires that the death certificate has been signed by the attending plates a should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3	Ectopic pregnand Other (s <i>pecify)</i>	cy		23d. Date Mon	e of delivery hth Day Year
rds, P	quires that n signed t	by	Part II. Other significant conditions of	ontributing to death	but not resul	lting in the ur	nderlying cause g	ven in Part I.			ibute to the cause of death?  3 Probably 4 Denknown
Vital Records,		Completed							24a. Was autor perfo 1 \( \text{Yes}	rmed? pr	Vere autopsy findings available rior to completion of cause of eath?
of	utending Physicien: The death. ctor: After this certificate y the funeral director, pag	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 Inpa 28a. Date of Ir (Month, I		ER/Outpatien 28b. Time of Injury	28c. Inju	her: 4 Nursin	-	/	or (Specify) HOSPICE ad
Division	Hospital or Attending 14 hours after death. Funeral Director: After tely filled in by the fune	Certification;	3 Suicide 4 Homicide 6 Could not be determined	building,	etc. (Specify)	)	eet, factory, office		City or Tov	vn, State)	er or Rural Route Number,
	To the Hosp within 24 hor To the Fune completely fi	ledical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysician: To the be niner: On the basis and manner	of examinati	viedge, death ion and/or inv	estigation, in my	opinion, death o	lace, and due to the occurred at the time,	cause(s) and man date and place, a	nner as stated. Indidue to the cause(s)
ŧ	To the within 2 Complet	W	29b. Signature and title of certifier	M	D		29c. Licen	3934			(Month, Day, Year) See 11, 2004
grs.	MAS		30. Name and address of person who a27 ST. PAUL	completed cause o		23a) (Type,		MD.	21202	Dwie	ьч II, 2004 БНТ D. Im, Мэ
	Sta Registi		31. Date filed (Month, Day, Year) NOV 1 5 200	32. Regis	strar's Signati	ure	board	,			

	•		1- For State of Maryland / Depar Registrar Certification	tment of Health and Mentificate of Death	tal Hygiene Reg. No.2	004 38189
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     Robert Daniel Leatherman  4a. Facility Name (If not institution, give street and number)		Date of Death Month Yember 21, 2	3. Time of Death 11:35PM M
	Funeral	CI	11920 Auburn Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Thurmont  If Under 1 Year   If Under 24 Hrs. 8. D  Months Days Hours Min. 1	Fre	ederick  9. Birthplace (Stete or Foreign Maryland
	Director wow	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local			10d. Inside City Limits 1 🗆 Yes 🛂 No
	h with the	ai Director		10f. Zip Code 21788	10g. Citizen of U.S.A	What Country?
ივი	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23e or 28e-f show that the Medical Estini or must be maillied at	by Funerai	3X Widowed 4 □ Divorced   If Yes, Give   1L	as Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ricar  Yes 27 No Specify:		ace - American Indian, ack, White, etc. ify: White
21215-0036	within 72 ho jiene. r then "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Deceder (Give kir life. DC) Stone  Stone	nt's Usual Occupation ind of work done during most of working O NOT use retired) 2—Brick Mason		Business/Industry
yland	ld be ental ked c	To Be C	Luther Elmer Leatherman	Elizabet	st, Middle, Maiden Surna th Powell	,
e, Mar	and 2 fealth a m 27 Is		20a Method of Disposition 20b. Place of Dispositi	Address (Street and Number or Rural Rou Sugar Bush Circle, F		D 21703
Baitimore,	t. Page ntment o rient: If njury or		X Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)	netery Nov. 24,	, 2004 Thur	mont, Maryland
e E	permi Depa Impo any ir		21. Signature of Fuoral Service Licenses  M00255  M00255  Z23. Part1. Enter the disease, or complications the caused the death. Do not enter shock, or heart failure. List only one cause of each line.			III(GI VAI DO(WGGI)
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  A Theroscleroit Condition at the condition resulting in death Due to (or as a consequence of):	Cardiovascular	Disease	Onset and Death 40 7041
	ecuted and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):			
<b>68/6</b> 0,	death certificate be executed e attending physician and od for use as the burial-transit	dical	d			
C. BOX	the death certific y the attending p iched for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ E	ictopic pregnancy Other (specify)		ate of delivery Ionth Day Year
ecords, P.	w requires that the de been signed by the a should be detached f	by	Part II. Suite significant conditions continuous to death out not resulting in the unit	erlying cause given in Part I.		ntnbute to the cause of death?
I	The law ate has b page 2 si	Completed		1	autopsy performed? 1 Yes 2 No	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
rvitai	Physicien: this certific ral director,	To Be	examiner?	26. Place of Death (Che		her (Specify)
o uc	Jing Tafter June				Describe how injury occu	
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office 28f. L	ocation (Street and Num. City or Town, State)	ber or Rural Route Number,
	To the Hospital within 24 hours of To the Funerel I completely filled	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death of the basis of examination and/or inversal manner stated.	stigation, in my opinion, death occurred at	the time, date and place,	, and due to the cause(s)
	will will	M	> // 75hm	29c. License number D 0035/52	Novem	ed (Month, Dey, Year) hber 22, 2004
	20		_ V	TOLARON DRIVE FR	Rolen. Il M	0 21702
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1		

		1 - For State Registra AMEND#26peri	MD11/16/04,BMW	,MbCo	Certificati	e of Death	7	Reg	. No.	3819
Physic /Medi Exami	cal	Decedent's Name (First, Middle     Mary     4a. Facility Name (If not institution	Jane	<b>1</b>	Lan 4b. City,	<b>eve</b> Town, or Location	N	2. Date of Death Month	Day Year 7, 2004 4c. County of De	10:30p
Funeral Director		13921 Mills At 5. Social Security Number 169 28 0591		ge (In yrs. last bii <b>68</b>	yrs. Si Si If Under Months	Iver Spri 1 Year   If Onder Days   Hours	Min. 8	3. Date of Birth (Month, Day, Y	ear) (	ery irthplace (State or Fore Country)
Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Monts	gomery	10c. City, Tow						10d. Inside City Lim
72 hours atter death with the Maryland natural', or Items 23a or 28a-f show died. Eventher must be notified at	Funeral Director	10e. Street and Number  7514 Weatherby  11. Marital Status  1 Never Married 2 Marr	12. Was Decedent Armed Forces	?	13. Was Deced	Code  20855  dent of Hispanic Or orly Cuban, Mexica	rigin? (Speci	fy Yes or No-	USA 14. Race - Am Black, Wh	nerican Indian,
permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show arry injury or other traumatic avant, Ite Medical Evantiar must be notified at once.	Completed by F	3 Widowed 4 XX ivorced  15. Decedent (Specify only highest Elementary/Secondary (0-12)	If Yes, Give Year or Dates:	16a	1 Tes  1. Decedent's Usua (Give kind of worlife, DO NOT us	al Occupation		, 16	Specify: b. Kind of Busines	White s/Industry
Stigute be med and Mental Hygie and Mental Hygie and markad othar tumatic avant, It.	To Be Co	12 17. Father's Name (First, Middle, Alfonse Hencial 19a. Informant's Name/Relationsl	C		Human Res	Jane	Jaro	cinski	Equitable iden Surname)  Sity or Town, State,	
ges I and a it of Health a if itam 27 is or other train		Jennifer Crisal  20a. Method of Disposition  1558urial 2 □ Cremation  4 □ Donation 5 □ Other (S)	3 Removal from State	er 13	3921 Mil. of Disposition (Namery, crematory or o	Ls Avenue	Silve Date	er Sprin	ng, Maryl o. Location - City o	and 20904 r Town, State
Department important:		21. Signature of Funeral Service	License	Gate	22. Name an	d Address of Facili	Hine:	s Rinald	i Funera	1 Home
hysician /Medical xaminer		23a. Part1. Enter the disease, or shock, or beart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	complications that ceuse only one cause on each line.  aMesoth_Due to (or as b	d the death. Do	22. Name an 11800 N not enter the mod of):	d Address of Facili	Hine:	s Rinald Ave Silv	er Sprin	1 Home g, MD 2090 Approximate Interval Between
e attending physician and Medical xam index to use as the burist-transit	dical Examiner	A3a. Part1. Enter the disease, or shock, or beart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate the conditions of the cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	complications that ceuse only one cause on each line.  a. Mesoth  Due to (or as)  b. Due to (or as)  c. Due to (or as)  d. 23c. If yes, outcome 1 to be birth 4 Pregnant a 9 Unknown	d the death. Do ine.  nelioma a a consequence a consequence a consequence of pregnancy 2 Fetal death t time of death	22. Name an  11800 1  not enter the mod  of):  of):  of):	d Address of Facili	Hines Shire A cardiac or n	s Rinald Ave Silv espiratory arrest,	23d. Date of de Month	1 Home g, MD 2090 Approximate Interval Between Onset and Death 1 Year
ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or shock, or beart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	complications that ceuse only one cause on each line.  a. Mesoth  Due to (or as)  b. Due to (or as)  c. Due to (or as)  d. 23c. If yes, outcome 1 to be birth 4 Pregnant a 9 Unknown	d the death. Do ine.  nelioma a a consequence a consequence a consequence of pregnancy 2 Fetal death t time of death	22. Name an  11800 1  not enter the mod  of):  of):  of):	d Address of Facili	Hines Shire A cardiac or n	s Rinald Ave Silv espiratory arrest,	23d. Date of de Month  co use contribute I  2  No 3 P  24b. Were a prior to death?	1 Home  g, MD 2090  Approximate Interval Between Onset and Death  1 Year  belivery Day Year  to the cause of death?
n.  After this certificate has been signed by the attending physician and multiple and inneral director, page 2 should be detached for use as the burial-transit and inneral director.	To Be Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or shock, or beart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	complications that ceuse only one cause on each if Due to (or as b. Due to (or as b. Due to (or as d. Due to	d the death. Do ine.  nelioma s a consequence s a consequence s a consequence of pregnancy 2   Fetal death it time of death out not resulting in	22. Name an  22. Name an  22. Name an  22. Name an  23. Table of the mod  25. Table of the mod  26. Table of the mod  26. Table of the mod  27. Table of the mod  28. Table of the mod  29. Table of the mod  20. Table of the mod  20. Table of the mod  20. Table of the mod  20. Table of the mod  20. Table of the mod  20. Table of the mod  20. Table of the mod  21. Table of the mod  21. Table of the mod  21. Table of the mod  21. Table of the mod  21. Table of the mod  21. Table of the mod  22. Table of the mod  23. Table of the mod  24. Table of the mod  25. Table of the mod  26. Table of the mod  26. Table of the mod  27. Table of the mod  28. Table of the mod  29. Table of the mod  20. Table of t	egnancy egrancy eause given in Part I  26. Place A Other: 4 □ Nu 3c. Injury at Work? 1 □ Yes 2 □	e of Death Cursing Home	23e. Did tobace 1 Yes  24a. Was an autopsy performed 1 Yes  Check onlone 6 Residence 1. Describe how in	23d. Date of de Month  co use contribute I 2 No 3 P 24b. Were a prior to death? 1 No 1 P 24b. Were a prior to death? 1 No 1 P 24b. Were a prior to death?	Approximate Interval Between Onset and Death  1 Year  Blivery Day Year  Tobably 4 Unknow outopsy findings availate completion of cause of 2 No
This certificate has been signed by the attending physician and interestor, page 2 should be detached for use as the burial-transit	o Be Completed by Physician/MedIcal Examiner	3a. Part1. Enter the disease, or shock, or beart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	complications that ceuse only one cause on each if a. Mesoth Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as	d the death. Do ine.  nelioma s a consequence s of pregnancy 2	22. Name an  22. Name an  11800 It not enter the mod  of):	egnancy egrancy ecify)  26. Place A Other: 4 \ Nu 3c. Injury at Work? 1 \ Yes 2 \ \ , office	e of Death Cursing Home No 286	23e. Did tobace 1 Yes  24a. Was an autopsy performed 1 Yes  Check onlone  Check onlone  City or Town, S	23d. Date of de Month  co use contribute to 2 No 3 Prior to death? No 1-2 Prior to death? No 1-2 Prior to death? The first to death? The first to death? The first to death? The first to death? The first to death? The first to death? The first to death? The first to death? The first to death? The first to death? The first to death? The first to death? The first to death? The first to death? The first to death?	Approximate Interval Between Onset and Death  1 Year  So the cause of death?  Probably 4 Unknowutopsy findings availar completion of cause is 2 No

Amended # 193, MLV

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

0 - 4151 4 -	- f Danth	
Certificate	or Death	

38191

		-	State Registrar		Cei	tificate of	Death		1	Reg. No.	007	00151
	4 6 6		1. Decedent's Name (First, Middle, Last	")					2. Date of De			3. Time of Death
	Physicia		EDITH E. LO	RAW				]	Month NOVEMI	BER :	16, 200	04 5:40 P <sup>M</sup>
ै	/Medic	_	4e. Facility Name (If not institution, give			4b. City, Town,	or Location				ounty of Death	
	Examin	er	CUMBERLAND VILLA		ER	CUMBER	LAND			A	LLEGAN	Y
	)		5. Social Security Number 6. Se			If Under 1 Year		r 24 Hrs.	8. Date of Birt	th	9. Birtl	nplece (State or Foreign untry)
۲.	Funeral		1[	DM 21X0F 94	Yrs.	Months Days	Hours	Min.	8. Date of Bird (Month, Da MAR • 1	y, Year) 3, 191	O WES	T VIRGINIA
	Director	}	233–42–8435 Usual Residence of Decedent							-,	- 1	
	and w	}	10a. State 10b. County	10c. City	/. Town or Lo	cation						10d. Inside City Limits
	sho	ž	WV MINERA	т. Р'	IDGELE	Y						1 ☐ Yes XXNo
	Sa-f	ect			- DOLLD	10f. Zip Code				10a Citiza	en of What Co	untry?
	in the	Director	10e. Street and Number	VII)		21502					S.A.	ondy.
	23e	rai	34 KNOBLEY STREE									deen Indian
	ems ma	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Or ban, Mexica	rigin? (Spec in, Puerto P	city Yes of No Rican, etc.)	·   '	<ol> <li>Race - Ame Black, White</li> </ol>	
9	afte or If		1 Never Married 2 Married	1 ☐ Yes 2X No Il Yes, Give		1 ☐ Yes 2 No	Specify:	<i>'</i> :		5	Specify: TAT	HITE
5-003	filed within 72 hours after death with the Maryland Hygiene. other than Insturel', or terms 23a or 28a-f show ent, the Mudical Evand art must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:						101 101		
ည်	72 h	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during mos	st of workin	ng	160. Kin	d of Business/	industry
2121	ithin	gr	Elementary/Secondary (0-12)	College (1-4or 5+)			•			110	CDTMAT	
7	ygier t,	Ö	12		LAUND	RY WORKE		ada Nama	(First, Middle,		SPITAL	
힏	tal H	Be	17. Father's Name (First, Middle, Last)								omame,	
Maryland	Ment	ဥ	HARRY G. WOLFE					TTIE	FROMH			
an	short and		19a. Informant's Name/Relationship (7	ype, Print)	1	ng Address (Stree						
	alth 27		JANET LEWIS / N		The second second second	TE 1, BC	X 473		-			
ē	item item		20a. Mathod of Disposition		lace of Dispo emetery, crei	sition (Name of matory or other pl	ace)		ate	20c. Loc	ation - City or	Town, State
Ë	Pages nent of ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	1 60	AY'S C	HAPEL	1	1/20/	2004	NE	WBURG,	WV
Baltimore,	그 원원 중 .		21. Signature/of Funeral Service Licen	see /	22	UPCHURCH	ess of Facil	יו דעלוי	IOME D	λ		
ã	Depa Impo eny ic		Whomal A.	Yorbuild		202 GREE	NE ST	REET.	CUMBE	RLAND	, MD	21502
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the deat								Approximate Interval Between
		9	Immediate Cause (Final	1	1+	- 1						Onset and Death
7	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	Meri	1 Dise	- vie					2915
	Examiner		1	200 (0) (0) 43 4 (95) 304	201100 01).	)						•
		<u>-</u>	Sequentially list conditions.	b. Lue to (or as a conseq	uerica ul').							
	led	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
_	and and	xar	that initiated events resulting in death) Last	C. Due to (or as a conseq	uence of):							
68760,	certificate be executed iding physician and ise as the burial-transit											
87	cate phys	/Medical		, d								
9 ×	ding se as	\Me	IF FEMALE:	23c. If yes, outcome of pregna	ancv					2.	3d. Date of del	iverv
Во	death o	ian	23b. Was decedent pregnant in the past 12 rejoriths?	1 Live birth 2 Feta	Ideath 3	☐Ectopic pregnan☐ Other (specify)	су			-	Month	Day Year
	the a	sic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9□ Unknown	9411 3	_ Other (specify)						
P.0	law requires that the death of as been signed by the atten 2 should be detached for u	Physiciar	Part II. Other significant conditions of	ontributing to death but not res	ulting in the I	inderiving cause o	iven in Part	1	23e. Did t	obacco us	e contribute to	the cause of death?
	res th	þ	Part II. Other significant conditions of	ornibuting to double but not rea	citary art are a	indonying occors	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10			obably 4 Unknown
5	w require been signature	Completed									7	
ည္ထ	Blawr has be	pie							24a. Was auto	psy	prior to	topsy findings available completion of cause of
Æ	0 - 0	E							1 Yes	2010	death? 1 ☐ Yes	2 No
Vital Records,	ician: Th certificate ector, pag	O	25. Was case referred to medical				26. Plac	ce of Death	(Check only	-		
>	00 00	0 8	examiner?	Hospital: 1   Inpatient 2	ER/Outpatie	nt 3 DOA	ther: (4CIN	dursing Hor	me 5 🗆 Resi	dence 6	Other (Spe	cify)
ō	ding Phy h. After this funeral o	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. In	ury at	2	28d. Describe	how injury	occurred	
o	Attending or death.  ector: After by the fune	10	Natural 5 Pending 2 Accident investigation		injury		Yes 2	]No				
/IS	Attend death ctor: /	fice	3 ☐ Suicide 6 ☐ Could not b	200. Flace of injuly - Acti		reet, lactory, offic	9	- 2			Number or Ru	ıral Route Number,
Division	after after Dire	Certification:	4  Homicide determined	building, etc. (Special	(y/)				City or To	, Jidle)		
	Hospitel 24 hours a Funerat I		29a. Certifier Certifying Pt	ysicien: To the best of my kno	owiedge, dea	th occurred at the	time, date a	and place, a	and due to the	cause(s) a	and manner as	stated.
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exar	niner: On the basis of examina and manner stated.	ation and/or in	nvestigation, in my	opinion, de	eath occurre	ed at the time,	date and	place, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				nse number				signed (Mont	
			1 /1/201	mo		00	0332	28/1		No	V, 17	2004
	5		30. Name and address of person who	completed cause of death (Itel	n 23a) (Tvne	. Print)	^	-0				2004
	C. D.		SUNI COM	M7-625	Kon	nt AVP	. (1)	inh	orlam	N	10 2	1502
		1	at Date Start (Month Day Wood)	32 Benistrar's Sign	atura V	21 4185	/	VILL	- I-u.l	,		

perus & sparks

ORIGINAL

Registrar

			State of Maryland / Department   State of Maryland / State of Maryland / State of Maryland   State of Maryland / State of Maryl	fificate of Death	Reg. N	2004	38192
			1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medio		Eugene Albert Lagace		November	18, 2004	1:45 AM <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death	
			42209 Ridge Road	Mechanicsville		St. Mary	
	Funeral		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last birthday</i> ) 1 XM 2 ☐ F 7. Age ( <i>In yrs. last birthday</i> ) 1 Yrs.	Months Days Hours Min.	B. Date of Birth (Month, Day, Year	r) Coun	
	Director		036-07-9483- 91 Yrs.  Usual Residence of Decedent	J	uly 8, 19	13 Rhod	le Island
	yland		10a. State 10b. County 10c. City, Town or Lo	cation		1	0d. Inside City Limits
	Mar e-f st	ctor	Maryland St. Mary's Mechanic	sville			1 ☐ Yes 2X No
	th the	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Coun	try?
	1th wi		42209 Ridge Road	20659	υ	.S.A.	
	er deg	Funeral	Armed Forces?	Vas Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
36	72 hours after death with the Maryland "neturel", or Items 23e or 28e-f show olical Examilier must be notified at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1941 − 1 □ Yes 3 1 ■ No 1941 − 1 □ Yes 3 □ No 1941 − 1 □ Yes Give Year or Dates: 1946	□ Yes 2 No Specify:		Specify:	
21215-0036	hour turel	ed b	1510	lent's Usual Occupation	166	Whi Kind of Business/Ind	
5	c <u>1</u>	Completed	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	7	Kind of Business/inc	lustry
77	within jiene r then "	mo	Elementary/Secondary (0-12) College (1-4or 5+)  12 Mas	on		Federal G	overnment
	be filed withintal Hygiene. Ind other then	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (			overment
Maryland	should be 1 nd Mental I marked of	To B	Wilfrid Lagace	Cornela	Tremblav		
ary	sho and N s ma		19a. Informant's Name/Relationship (Type, Print) Executor/ 19b. Mailin	g Address (Street and Number or Rural I		or Town, State, Zip	Code)
	and 2 saith n 27 i		Brenda S. Davis / P.O.A. 272	02 Cleveland Stree	t Mechani	csville M	D 20659
ore	of He of He fiten		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ Rengoval from State  20b. Place of Disposementery, crem	natory or other place)	te 20c. L	ocation - City or To	wn, State
Ĕ	Pag nent ent: I		'4 Donation 5 Other (Specify) Immaculat	Mary	2004 Lex	ington Pa	rk. MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumetic expres.		21. Signature Funeral Service Licensie 22		nsfield F		
_	2012 2	9		955 Hollywood Road	Leonardt		
П			23a. Pagh. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or i	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Find disease or condition	TANULE			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	FAILURE INVETIVE PULMOS	. 10 0		
	Lxammer			PUCTIVE PULMER	VARY L	rease	YEARS
	ed sit	lner	if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): cause (Disease or injury				
	cate be executed physician and the burial-transit	Exam	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
68760,	be e Sician buria						
687		edical	d				
Box	death certifi e attending p ed for use as	ician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliver	v
ğ	death e atte d for	icia	in the past 12 months?  1 Ves 2 No. 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)			Day Year
P.O.	that the de ted by the a detached f	Physi	9 ☐ Unknown 9 ☐ Unknown				
	res tha igned I be det	by P	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco	use contribute to the	e cause of death?
4.	sic db		COLONARY MIERY DISEAS			□No 3 Proba	ably 4 Dunknown
ro	inbe	ě		<u> </u>	1 Yes 2		
ecord	law requir as been s 2 should	pletec		<u>C</u>	24a. Was an	24b. Were autop	sy findings available
Record	e law requ has been je 2 shouli	completed			24a. Was an autopsy performed?	prior to con death?	pletion of cause of
ital Record	The ate h page	3e Completed	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed?	prior to con death?	pletion of cause of
of Vital Record	ysicien: The is certificate h		examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (	24a. Was an autopsy performed?	prior to com death? 1 □ Yes	npletion of cause of 2 ☐ No
n of Vital Record	ng Physicien: The Iter this certificate h ineral director, page	To Be	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient  27. Manner of Death  28a. Date of Injury  About 1 Directors Injury  28b. Time of	26. Place of Death ( 3 DOA Other: 4 Nursing Home 28c. Injury at 28d Work?	24a. Was an autopsy performed? 1 Yes 2 D No.	prior to comdeath? 1  Yes	npletion of cause of 2 ☐ No
sion of Vital Record	ng Physicien: The Iter this certificate h ineral director, page	To Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient  27. Manner of Death 1 North, Day Year) 2 Accident investigation 2 Suiside 6 Could not be	26. Place of Death ( 3 DOA Other: 4 Nursing Home 28c. injury at 28c Work? M 1 Yes 2 No	24a. Was an autopsy performed?  1 Yes 2 DANG  Check onlone  5 D december de	prior to comdeath? 1 Yes:	npletion of cause of 2 □ No
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 19 2004 9:10 AM Margaret Lister November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 T F 005-46-7542 Director 67 May 3, 1937 England Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "neture!, or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified. 1 Yes XXNo Director Maryland St. Mary's Lexington Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21262 Joe Baker CT. Apt. #B6 20653 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Health Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Tom Lister 2 Olive Chilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20653 19a. Informant's Name/Relationship (Type, Print) Olive Lister / Mother 21262 Joe Baker Court, Apt. B5, Lexington Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11-20-2004 | Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Euperal Se Edward N. Brinsfield, M00052 22955 Hollywood Road Leonardtown, Maryland 20650 Jr. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Immediete Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): Examiner 5-quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of): Examiner The law requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequent Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dea use 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 1 No the detached 9 Ulnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ should be 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? funeral director, page 2 1∏ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Yes 2 No 3□ DOA 4 Nursing Home 5 Residence 6 □Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: 2 Accident in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide filled 🧭 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D (Type, Print) 30. Name and address of person who completed cause of death (Item Jarboe, 24035 Three Notch Road Hollywood, Maryland 20636 James Ρ. M.D 31. Date filed (Month, Day, Ye 32. Registrar's Signature 2004 Registrar

		1	For State Registrar		State	of Marylan		artment <i>rtificate</i>			and M		giene Reg. N <b>á</b>	1000	38194
	Physici	an	1. Decedent's Name  Claire	(First, Middl	e, Last) Lloyd							2. Date of Dea Month	Day	2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If r	not institutio	n, give street and no	ımber)		4b. City, To	own, or	Location o	of Death	~	-	County of De	eath
			308 E.	Villa	ge Rd.			E11	ktor	1				Ceci]	l
	Funeral Director		5. Social Security Nur 222-07-17		6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs.	last birthday)  Yrs.	If Under 1 Months	Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Day 10/22/	h y, <i>Year)</i> 1919	9. E <b>DE</b>	Birthplace (State or Foreign Country)
	g ,	-	Usual Residence of D	Decedent 10b. County		10c Cit	ty, Town or Le	anation							10d. Inside City Limits
	shov	-						Joanon							1x Yes 2 No
	Ba-f	Director	MD		cil	I	Elkton	101 71 0	N = 4 =				10- 04	non of Milana	
	ill or s		10e. Street and Numl					10f. Zip C						zen of What	Country?
	ath v	ra	308 E. Vi	llage			10		921		-1-0 (0-		US		merican Indian,
21215-0036	i within 72 hours after death with the Maryland liene r than "naturel", or Items 23s or 28s-f show The Medical Everyliner must be notified at	by Fun	<ul><li>11. Marital Status</li><li>1 ☐ Never Marries</li><li>3 ☒ Widowed 4</li></ul>		ried Armed F	2 ▼ No ive		was Decede If Yes, specif		Specify:		ecify Yes or No- Rican, etc.)		Black, W	
9-0	72 ho	ted	(Specific	15. Deceder	it's Education st grade completed	1	16a. Dece	dent's Usual kind of work	Occupa	ation	t of work	na	16b. Ki	nd of Busine	ss/Industry
21	within 7 ene. than "r	Completed	Elementary/Secon		-T	/ (1-4or 5+)	life.	DO NOT use	retired,	)	t or morni	9			
2		Con	1	2			h	omemak	er					n home	2
Maryland	be filed vital Hygie of other feether	Be	17. Father's Name (F									(First, Middle,		Sumame)	
<u>\</u>	should be ind Mental is marked o	<sup>2</sup>	F. Ray Ph				40h Mail	Add /	'C44			. Campb		Tour Ctote	7in Code)
Mai	2 m m		19a. Informant's Nar			,						al Route Numbe			3, 21p C009)
ຜົ	s 1 and 2 if Health item 27 other tre		Linda L.  20a. Method of Dispo		(daughte		Z4Z1 Place of Disp			Will		ton, DE			or Town, State
0	ges if of F		1 Surial 2	Cremation	3 Removal from	1 State	cemetery, cre	matory or oth	er place					·	
Ë	tent:		` 4 □ Donation 5			Si	llverb					0/2004	Wil	mingto	on, DE
Baltimore,	permit. Pages: Department of the Importent: If ite any injury or of once.		21. Signature of Fan	Hay L	). though	lli	l	3924 C	y Fu	inera. ord Pl	1 Hon	mes, In Wilming	ton.	DE 19	803
			23a. Part1. Enter the shock, or heart	e diseas <i>e</i> , o failure. Lis	r complications that t only one cause on	caused the deal each line.	th. Do not en	ter the mode	of dying	g, such as	cardiac	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
	Pinysician		Immediate Cause (F		. ( "	repro V	lascul	· Ac	cir	lent					1 m onth
	/Medical		resulting in death)			(or as a consec	quence of):								
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	be sit	Examlner	Sequentially list con- if any, leading to im- cause. Enter Under Cause (Disease or in	nediate lying	Due to	(or as a consec	quanea or).								
	ate be execute hysician and the burial-trans	am	that initiated events resulting in death) La		c										
30,	e exection significant	ũ	1930king in Godin, Le	451	Due to	o (or as a consec	quence or):								
8760,	ate b hysic the b	lcal			d										
9	e as	Mec	IF FEMALE:		20.1/										
Вох	death certificate be executed e attending physician and ind for use as the burial-transit	Physician/Med	23b. Was decedent in the past 12 n		1 Live	utcome of pregn birth 2 ☐ Feta	aldeath 3	Ectopic pre					2	23d. Date of Month	delivery Day Year
0	the a	sic	1 ☐ Yes 2 X		4∐Preg 9☐ Unk	gnant at time of o nown	death 5	Other (spec	cify)						•
Ρ.	at the d d by the etached	Phy	Part II. Other signific	ant andit	ione contribution to	dooth but not ro	sulting in the	undorhing on	UCO 011/0	on in Part I		23a Did to	nhacco II	ise contribute	to the cause of death?
S,	law requires that the as been signed by th 2 should be detache	by	Part II. Other signific	Jant Condit	one contributing to	abatii bat not ros	suiting in the t	and onlying car	u30 g. re	on my caren	•	1 🗆 1		2	Probably 4 □Unknown
Orc	v requi	eted												1	
Records,	has t	Completed										24a. Was autop		24b. Were prior t death	autopsy findings available to completion of cause of ?
	T ate	Col										1 🗆 Yes	2 No		es 2 No
Vital	Physiclen: The this certificate ral director, page	Be	25. Was case referre		Hospital				Othe	-		(Check only o		4	Grand doughters
of	Phys this al dii	5	1 ☐ Yes 2 ♣ 1		1	Inpatient 2	ER/Outpatie		1	4 🗆 140	-	me 5 Resid		6 X Other (S	pecify)
L	ding I h. After funer	lon	1 Natural	5 Pendi	ng (Mo	nth, Day Year)	Injury	M	Work	<br Yes 2□				,	
Sign	r Attending er death. rector: Alter by the fune	ical	2 Accident 3 Suicide	6 Could		ce of Injury - At h	lome farm s					28f. Location (S	Street an	d Number or	Rural Route Number,
Division	after Direction by	Certification:	4 Homicide	deten	mined buil	ding, etc. (Speci	ify)	root, ractory,	011100			City or Tox			
	spite ours larel filled		29a, Certifier	1 Certifui	ng Physician: To t	ne best of my kn	owledge. dea	th occurred at	t the tim	ne, date an	nd place	and due to the	cause(s)	and manner	as stated.
	To the Hospitel or Atteni within 24 hours after deati To the Funerel Director: completely filled in by the	ledical	(Check only one)	2 Medica	Examiner: On the	basis of examination	ation and/or i	nvestigation, i	in my op	pinion, dea	ith occur	ed at the time,	date and	place, and o	due to the cause(s)
	To To To To	Σ	29b. Signature and t	title of certifi	Man m	D		296.	)   t	number	4			-	-17, 2004
	15		30. Name and addre	ess of person	who completed ca	use of death (Ite	т 23а) (Туре		m	' / l	-1		, V V I		
			31. Date filed (Mont	h Day Year	1 6 30	Registrar's Sign	ature	on.	11/1						
	Sta Regist	ate rar	NOV 1	9 2004	Blen	15	parte								

Funeral Director			□ M 2 □ F 57	Yrs.	Months Days		8. Date of Birth (Month, Day, ) April 3,	1947 Mar	thplace (State or For ountry) yland
how		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Lo	ecation				10d. Inside City Lin
Sallife	Funeral Director	VA Prince W	Villiam W	oodbri	<u> </u>		100	2. Citizen of What C	1 Yes 2
a or	Ö	13775 Mellowdew	Count		10f. Zip Code 2219;	9	100	U.S.A.	ountry r
na 23	era	13773 FIETTOWGEW	12. Was Decedent Ever in U	J.S. 13.		Hispanic Origin? (Spectan, Mexican, Puerto F	cify Yes or No-	14. Race - Am	
it health and Merical Hygiene. item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, it a Medical Examiner round be inclifted at	Ď	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 ☐ No		Rican, etc.)	Black, Whi	<sub>te, etc.</sub> White
natur.	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occu	pation during most of working	16	6b. Kind of Business	/Industry
. u	nple	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of workingd)		<b>3</b> 6	
tygier her ti nt, th	ပိ	12 17. Father's Name (First, Middle, Last)		Mai	nager	18. Mother's Name	(Eirst Middle Ma	Manufact	uring
and Mental Hygiene. Is marked other than aumatic event, It a M	Be C	George R. Mays				Vera V. V		roen comane,	
nark mark matic	၉	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailir	ng Address (Street	t and Number or Rural		City or Town, State,	Zip Code)
27 Is		Anna Mays/Wife		1377	5 Mellowo	lew Ct., Wo	oodbridg	e.VA 2219	3
Health a item 27 la othar tra		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other pla	Da		c. Location - City or	
nnt: If iny or		1 🌠 Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State			metery 11/1	17/04 A	lexandria	, VA
Department of Important: If ite any injury or of once.		21. Signature of Runeyay Service Licen	(Illon	22	Name and Address Mountca 4143 Da	ess of Facility astle Funer ale Blvd.,	ral Home Dale Ci	ty, VA 22	193
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final							Approximate Interval Betwee Onset and Dea
hysician /Medical		disease or condition resulting in death)	Bue to (or as a consecutive of the consecutive of t	guence of):					
xaminer		Sequentially list conditions	b. Empyema						_
s #s	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec						
ician and burial-transit	хап	that initiated events resulting in death) Last	c. Thoracot Due to (or as a consec						_
ysician and	calE		Lung Can						
			0						
r death.  color: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregn 1 Live birth 2 Fet. 4 Pregnant at time of 6	aldeath 3[	Ectopic pregnance Other (specify)	y 		23d. Date of de Month	livery Day Yeal
ed by t	Phy	9 ☐ Unknown  Part II. Other significant conditions or	ontributing to death but not re-	culting in the u	aderhijaa causa a	wen in Part I	23e Did toba	cco use contribute to	the cause of death
signe d be d	d by	Tarrit. Other signment conditions of	onthibuting to death but not re-	salling in the a	ricerrying cause gr	voiring caret.		2 □ No 3 □ P	
been sign should be	ompleted						24a. Was an	24h Were a	utoney findings avai
ate has	dm						autopsy performe	id?   death?	utopsy findings ava completion of cause
ector, pag	ပိ	25. Was case referred to medical				26. Place of Death	(Check only one)		₹XNo
h. After this certific funeral director,	0	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatient 2	] ER/Outpatier	nt 3 DOA	her: 4 Nursing Hom			cify)
ter th	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		ry at 2	8d. Describe how		
death. stor: Af	atic	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	1	.,.,		Yes 2□No			
within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	eet, factory, office	2	8f. Location (Stre City or Town, .	et and Number or R State)	ural Route Number
24 hour Funera	ledical (	29a. Certifier 1 M Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	ime, date and place, a opinion, death occurre	nd due to the cau d at the time, date	se(s) and manner a and place, and due	s stated. e to the cause(s)
	Me	29b. Signature and title of certifier	3		29c. Licen	se number	290	. Date signed (Mon	h, Dey, Year)
within To the	-	(2)							

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 2004 **Physician** 24, 0905 M Alma McCready Constance /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner 5864 Winter Oaks Place Frederick Frederick 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Bar Year) 921 6 Sax 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🖫 F 83 212-20-5464 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location rthan "natural", or Items 23a or 28e-f show the Medical Examinar must be notified at 1 TYes 2 □ No Calvart Maryland Lusby Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 12867 McCready Road 20657 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. nii. Pages 1 and 2 should be filed within 72 hours atter arment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural; or lie injury or other traumatic event, itse Madical Examina 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government Secretery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Elizabeth Unknown James Henry McCready 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Judith O. Whitmore/Daughter 5864 Winter Oaks Place, Frederick, MD 21704 20b. Place of Disposition (Name of pengetery, crematory or other place)

Smithsburg Crematory Nov. 26, 2004 Smithsburg, Maryland 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Keeney and Basford Funeral Home MO20021 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

105 East Church Street, Frederick,
Approximate
Interval Between
Onset and Peath
Onset and Peath
Onset and Peath Immediate Cause (Final disease or condition resulting in death) **Physician** 2 day > 0-0515 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an has t autopsy perform page certificate 1 Yes 2 No To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) DOWN WIN Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 20ther (Specify) resident 1 Yes 2 No 2 ER/Outpatient 2 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 Yes 2 No within 24 hours after useum.
To the Funeral Director: # investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the time. 29a. Certifier Medical (Check only one) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 010105 2260 NOV 24 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) alizandra, VA SAMIC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 2 2004 Registrar

	1- For State of Maryland / Department of Certificate of Certificat	Health and Me	-	ne 2001, 2010	77
	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Dea	ath
Physician /Medical	Joseph Benjamin Moore		November	19, 2004 7:30 pm	n M
Examiner		or Location of Death		4c. County of Death	
	Greater Baltimore Medical Center Towson  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea	r If Under 24 Hrs.		Baltimore .	
Funeral Director	214-24-3754   12XM 2 F 76   76   76   76   76   76   76   76	s Hours Min.	8. Date of Birth (Month, Day, Yea March 28,	9. Birthplace (State or For Country) 1928 West Virgini	reign La
/land	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Lir	imits
6 after death with the Mary or terms 23a or 28a-f sh of we must be mutified.	PA York New Freedom			1 ☐ Yes 2 📉	∑ No
with the a or 2	10e. Street and Number 10f. Zip Code			Citizen of What Country?	
leath ns 23 must	18110 Brose Road         17.3           11. Marital Status         12. Was Decedent Ever in U.S.         13. Was Decedent of			J.S.A.  14. Race - American Indian,	
Baltimore, Maryland 21215-0036  Bealtimore, Maryland 21215-0036  Departit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  To see the page of the train of the train of the page of the train of the page of the train of the page.  To Be Completed by Funeral Director	Armed Forces? If Yes, specify Cu  1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes 7 Dates:	Hispanic Origin? (Spec ban, Mexican, Puerto R o <i>Specify:</i>	Rican, etc.)	Black, White, etc.  Specify: White	
5-0036 72 hours after readural; or lineaural;  15. Decedent's Education 16a. Decedent's Usual Occ (Specify only highest grade completed) (Give kind of work don	pation	16b.	. Kind of Business/Industry		
21215-01 21215-01 21215-01 Signal attury 1. If the Medical Completed	Elementary/Secondary (0-12) College (1-4or 5+) Manufacturin	e during most of working		ectro Chemical	
d 21 filed wi Hygien ther th int.	11 Manufacturin 17. Father's Name (First, Middle, Last)	18. Mother's Name		nufacture	
Maryland Maryland d 2 should be file than d Mental Hy treumatic event To Be	Clarence A. Moore	Kather	ine O. E	Eberhart	
Mar Mar nd 2 sho lith and 27 is m				y or Town, State, Zip Code) Om , PA 17349	
altimore, Malaimente, Malaiment of Health an outmant of Health an outmant. If them 27 is injury or other treues.	20a. Method of Disposition 20b. Place of Disposition (Name of			Location - City or Town, State	
Page ment of uny or	1 XBurial 2 Cremation 3 XRemoval from State 1 Donation 5 Other (Specify)  New Freedom Cemeter  New Freedom Cemeter	, _, _ ,		ew Freedom, PA	
Balt permit Depart Import Import any in any	21. Signature of Jun val Service icenses  22. Name and Add  J. J. Har	ress of Facility tenstein nd St., N	Mortuar	y, Inc. dóm, PA 17349	
	23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, of near failure. List only one cause on each line.			Approximate Interval Between	1
Physician /Medical	Immediate Clause (Final disease or condition resulting in death)  a. Non-Small-Cell Lung	Lancer		Unknow N	1
Examiner	Due to (or as a consequence of):			,	
d die d	Sequentially list conditions, if any, leading to immediate cause. Enter the defiying Due to (or as a consequence of):				
8760, sate be executed hysician and the burial-transit direct Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):				
ai bur be 66	d				
. 0 = g s	IF FEMALE:				
P.O. Box 687 nat the death certificate the the attending physetached for use as the	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown	ју 		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	iven in Part I.	23e. Did tobacco	o use contribute to the cause of death?  2 No 3 Probably 4 Dunkno	
ecord law requir as been si 2 should			24a. Was an	24b. Were autopsy findings availa	
II Record The law requirate has been spage 2 should			autopsy periormed?	prior to completion of cause death?	of
of Vital F Physiclen: Th this certificate this certificate ral director, pag	25. Was case referred to medical examiner?	26. Place of Death			
Of Physical direction of Topics of T	1 Yes 2 10 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury Williams 5 Pending (Month, Day Year)	4   Nursing Home	e 5 Residence  3d. Describe how inj	6 ☐Other (Specify)	_
ion on anding Math.	1 Natural 5 Pending (Month, Day Year) Injury We	ork? ]Yes 2∐No			
Division of Vital Records, tel or Attending Physicien: The law requires tris after death.  In Director: After this certificate has been signed in by the funeral director, page 2 should be certification; To Be Completed by	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	Bf. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)	
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	29a. Certifier (Check only one)  Certifying Physician: To the basis of examination and/or investigation, in my and manner stated.	ime, date and place, an opinion, death occurred	nd due to the cause( d at the time, date a	(s) and manner as stated. and place, and due to the cause(s)	
To the within To the compl		se number	29d. D	Date signed (Month, Day, Year)	
	Chokut Donegur (Oncologist) Doo	56919		11/20/04	
10	30. Name and address of person who impleted cause of death (It in 23a) (Type, Print) RODOR+ Donegan 6569 N. Charles St. Ste 2	55 Baltim	ore, MD:	21204	1
State Registrar	31. Date filed (Month, Day, Year)  DEC 0 2 2004  32. Registrar's Signature  Aparticular				

			1 - State 11-17-04 Registrar Amend #23a.Prt		and / Depa vs.PCC <b>Ce</b>	artment of I	Health ar Death	-	Reg. No.		38198
i Sa	Physici /Medic		Decedent's Name (First, Middle, Last     Johnny Lee M	cBride				2. Date of De Month Novem	ber 8, 20	004	3. Time of Death 9:52 a M
-	Examir		4a. Facility Name (If not institution, give Montgomery Gener			4b. City, Town, 01ne		Death	4c. County Montg		
	Funeral Director		5. Social Security Number 6. Se 253-52-2597		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi (Month, Di June 1	nh av. Year) 0, 1929		ce (State or Foreign
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturet", or items 23e or 28e-f show any injury or other traumatic event, the Madical Examinating the rollined at Once.	neral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince G  10e. Street and Number  701 Elfin Drive  11. Marital Status	eorge C		Heights  10f. Zip Code 20743  Was Decedent of	Hispanic Origin	n? (Specify Yes or No		/hat Country State	Indian,
9600	hours after uret, or its	d by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 🛣 No	Specify:	Puèrto Rican, etc.)	Specify.	Diacr	C
Maryland 21215-0036	d within 72   giene. ir then "net line Medica	Completed by Funeral	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12) 10th		(Give	dent's Usual Occu kind of work done DO NOT use retire rer	during most o	of working	16b. Kind of Bu		stry
yland	ould be file I Mental Hy varked other vatic event,	To Be (	17. Father's Name (First, Middle, Last) Robert McBride				Josep		tehead		
	Health and 2 sh Health and 1 sem 27 is mother traum		19a. Informant's Name/Relationship (7) Doretha Whitehead  20a. Method of Disposition	/ Aunt	1786	Hwy 24E	ast Lou	or Rural Route Numb isville, (		30434	
Baltimore,	t. Pages tment of rant: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)			natory or other pla Springile hurch Cer		/17/04	Louisvi	11e, G	Georgia
Ba	permi Depar Impo any ir		21. Signature of Funeral Service Licens	Mos				e Funeral ke Forest			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complished. From the failure. List only o immediate Cause (Final disease or condition resulting in death)	ne dause on each line.	stole	er the mode of dyi	ng, such as ca	rdiac or respiratory a	rrest,	In O	pproximate Iterval Between Inset and Death Inset and Death
, o		Examiner	Superitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HYPE]  Due to (or as a cons		ON					
O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	etal death 3	Ectopic pregnanc	у		23d. Date Mon	of delivery th Da	ay Year
2	w requires that the part of th		Part II. Other significant conditions con Un witness Candiac		esulting in the u	nderlying cause giv	ven in Part I.		obacco use contri Yes 2 □ No	bute to the o	,
al Records,		Completed by	ventricular i	errlyTmrla	/			24a. Was auto pendo 1  Yes	psy pr prmed? de		r findings available letion of cause of
on of Vital	ing Phy After this uneral d	tion; To Be	25. Was case referred to medical examiner?  1	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ner: 4 🗆 Nursi				
Division	ital or Attandi rs after death. al Director: A led in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, str cify)	set, factory, office	•	28f. Location (. City or Tou	Street and Numbe wn, State)	r or Rural R	oute Number,
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exemi	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death	occurred at the tivestigation, in my	me, date and popinion, death o	place, and due to the occurred at the time,	cause(s) and man date and place, ar	ner as state nd due to th	e cause(s)
	To the To the complet	Σ	29b. Signatule and title of certifier	w m		29c. Licens	28791	)	29d. Date signed		
)	5)		30. Name and address of person who or Koger Leonaru M	18101 Prince	2 thilip (	Print) Olne	4 mp	20832			•
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 1 7 2004	22. Registrar's Sig	nature	2.					

			1 - For State Registrar	State	of Maryla		artment rtificate			ınd Me		ene 0	04	38199
	Physici	an	Decedent's Name (First, Min	ddle, Last)						1	2. Date of Death	Day	Year	3. Time of Death
	/Medic		GLADYS		MAP	ILY					OVEMBER	11	2004	1:30 P M
-	Examin	ięr	4a. Facility Name (If not institu		nu <i>mber)</i>				Location of	f Death			nty of Deatl	
9	Francis	2	8610 Hamlin  5. Social Security Number	6. Sex	7. Age (In yrs	ast birthday)	Lan	dove	If Under 2	24 Hrs.   8	B Date of Birth			eorge's
L	Funeral Director		577-40-3138 Usual Residence of Decedent	1 ☐ M 2 <b>反</b> F		Yrs.		Days	Hours	Min.	3. Date of Birth (Month, Day, uly 28	Year) 1920		nplace (State or Foreign untry)
	72 hours after death with the Maryland naturel', or Items 23c or 28e-f ahow Jical Examinational be notified at		10a. State 10b. Cou	nty	10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	n the Maryland r 28a-f ahow	Funeral Director	MD Prin	ce George	s	Land	lover							1 🕱 Yes 2 🗆 No
	ith the	Oire	10e. Street and Number				10f. Zip (	Code			10	g. Citizen o	of What Co	untry?
	ath w	rai	8610 Hamlin				2	0785	j			U.S.		
	ltems	une	11. Marital Status 1 □ Never Married 2 □ N	Armed	ecedent Ever in t Forces? s 2 <b>X</b> No	U.S. 13.	Was Decede If Yes, specif	ent of His ify Cubar	spanic Orig n, Mexican,	in? (Speci , Puerto Ri	ify Yes or No- ican, etc.)		ace - Amer lack, White	rican Indian, a, etc.
36	irs aff	by	3 XVidowed 4 Divord	If Yes	Give		1□Yes 2	X No	Specify:			Spec	city: <b>B</b> ]	lack
21215-0036	d within 72 hours after death with jiene. jiene. rrthen "naturel", or Items 23s or Ite Maulcel Examiliar in uet be.	ted	15. Deced	lent's Education		16a. Dece	dent's Usual	Occupa	tion		1	6b. Kind of	Business/I	ndustry
215	within 7 ene. than "n	ple	(Specify only hig Elementary/Secondary (0-12	hest grade complete  College	d) (1-4or 5+)	1	kind of work DO NOT use	k done di e retired)	uring most	of working	7			
2	filed wi Hygien other th	Completed	12th				Clerk						nment	
Maryland	be d d d	To Be	17. Father's Name (First, Midd Herman Min						18. Mother		First, Middle, M Willia		ame)	
lan	iges 1 and 2 should it of Health and Men I if item 27 is marke or other traumatic		19a. Informant's Name/Relation	onship (Type, Print)		19b. Mailir	ng Address (	(Street ar	nd Numbei	r or Rural I	Route Number,	City or Tow	m, State, Z	ip Code)
	is 1 and 2 of Health a item 27 ls other trav		Jose Mapily,	Son	1001					-	inham, 1			
altimore,	iges 1 au it of Hea if item or othe		20a. Method of Disposition 1 Burial 2 Trematic	n 3 Removal fro	III State	Place of Dispo cemetery, cren			1	Dat	7.4			Town, State
tim	Department Department Mportant: any injury		`4 □Donation 5 □ Other		Ri						/04 Ri			
Ba	permit. Pages Department of It Important: If ite any injury or of		21. Signature of Funeral Servi	shall	1	74	474 La	andov	ver R	oad I	. Jenki: andover	, Mar		
10	Pnysician		23a. Part1. Enter the disease shock, or heart failure. L Immediate Cause (Final disease or condition	ist only one cause of	t caused the dea n each line. rocardia				, such as o	cardiac or r	respiratory arres	st,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due	o (or as a conse	quence of):								
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	nsit	Examine	Cause (Disease or injury	<	- (0. 00 - 001100	4-2								
Ć.	cate be executed obysician and the burial-transit	Еха	that initiated events resulting in death) Last	c	o (or as a consec	quence of):								
8760,	ate be	edicai		d										
9	rtifica ng ph as th	Medi	LE SENALE.									11		
Вох	death certificate be executed e attending physician and d for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	outcome of pregn		Ectopic pre	gnancy					ate of deliv	*
0		sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at time of o		Other (spec						Aonth	Day Year
٩.	that the de ned by the a detached f	Ph	Part II. Other significant cond	itions contribution to	death but not re-	culting in the ur	adorh ing on		in Bort I		23a Did toba	000 460 00	ntributo to I	the source of death?
Records,	The law requires that the te has been signed by thoage 2 should be detache	ted by	Tarri, Ottor significant cond	indon's contributing to	death but not res	salang in the ur	idenying cat	use giver	in Parti.		_			the cause of death? bably 4 Unknown
ecc	has be	Completed									24a. Was an autopsy	24b	. Were auto	opsy findings available
<u>ш</u>		Con									performe		death?	2 <b>1</b> No
Vital	ysician: This certificate director, pag	Be	25. Was case referred to med examiner?							of Death (	Check only one,			
of	Physician: r this certifica ral director,	2	1 Yes 2 No			ER/Outpatien			4 LI NUIT		5 Residen			fy)
	tending Path. tor: After the funer	lon	27. Manner of Death 1 XNatural 5 ☐ Pen	ding (Me	e of Injury onth, Day Year)	28b. Time of Injury	M 28	work?			d. Describe how	injury occi	urred	
Division	tend leath tor: the	icat	3 ☐ Suicide 6 ☐ Cou	stigation Id not be	ce of Injury - At h	nome farm stre			es 2□N		Location (Stre	et and Nun	abor or Pur	al Route Number,
<u>&gt;</u>	after Dire	Certification:	4 Homicide dete		ding, etc. (Speci		Joi, Idolory,	Onioe			City or Town,	State)	ibor or righ	ar riodie reamber,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)	ying Phys)cian: To t al Exeminer: On the	he best of my kno basis of examina inner stated.	owledge, death ation and/or inv	occurred at restigation, in	t the time	, date and nion, death	place, and	d due to the cau at the time, dat	se(s) and n	nanner as s	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and the or cert				29c.	License	number		290	I. Date sign	ed (Month,	Day, Year)
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)	(P)		30. Name and addless of pers	on who completed ca	use of death (Iter	m 23a) (Type. I	Print)			- /		. (0		(
	(15)		Ronald Wheele				,	Largo	o, Ma	ry1an	d 20774			
	Sta Registr		31. Date filed (Month, Day, Ye NOV 1 8	ar)	Registrar's Signa	at <u>ure</u>								

			1 - For State Registrar	State of M	aryland		artment o			Re	g. No2 () ()	L.	3820	Ω
	Physici /Medic		1. Decedent's Name (First, Midd INOSENTE		ORGA					2. Date of Death	r <sup>Day</sup> 14, 2	7004	3. Time 6+ Death 13:25	y v
	Examir		4a. Facility Name (If not institution	on, give street and number)			4b. City, To	wn, or Locat	tion of Death		4c. County of	Death		
			SHADY GROVE  5. Social Security Number	ADVENTIST HC			GAITI	HERSBU	IRG nder 24 Hrs.	0.0	MONTGO			
	Funeral Director		none Usual Residence of Decedent	1.XM 2□F	54 (In yrs. las	Yrs.		ays Hou		8. Date of Birth (Month, Day, Oct. 15	, 1950	Country	ce (State or Forei r) uras	gn
	yland		10a. State 10b. Count	у	10c. City,	Town or Lo	cation					100	I. Inside City Limit	s
	e Mar	ctor	Md. Mon	tgomery	Ga	ither	sburg						1∭Yes 2□N	0
	with th	Funeral Director	10e. Street and Number 8855 Cross Co	untwr Dlago			10f. Zip Co				g. Citizen of Wh		17	
	eath is 23	erai	11. Marital Status	12. Was Decedent	Ever in U.S.	13.1	208		Origin? (Sno		Hondura:		Indian	
21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23s or 28s-f show any njury or other traumatic event, it to Madical Examiner must be notified at ances.	ğ	1 X Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried Armed Forces	,		f Yes, specify		city: Hon	ocify Yes or No- Rican, etc.) duran		White, etc.	2.	
2	72 ho natur	Completed		ent's Education est grade completed)		16a. Deced	dent's Usual C	ccupation	most of worki	1	6b. Kind of Busin	ness/Indu	stry	
7	within ne.	mple	Elementary/Secondary (0-12)		5+)	life.	Dish	washe	r	rg	Holida	av Tn	n	
р В	filled v Hygie other t	ပိ	3rd 17. Father's Name (First, Middle	, Last)				18. M	lother's Name	(First, Middle, M		-) -11		
an	lid be lental ked o ic eve	To Be	Ruben Altans	o Cedillo Le	nus					a Mayorg	,			
Maryland	and M s mar	-	19a. Informant's Name/Relation			19b. Mailir	g Address (S	treet and Nu	ımber or Rura	l Route Number,	City or Town, St	ate, Zip C	ode)	_
	and 2 ealth m 27 I		Osmar Cedillo	Mayorga (Bro					the state of the s	_	ithersbu	ırg,	Md. 2087	9
altimore,	Pages 1 nent of H int: If itel		20a. Method of Disposition 1 ■Burial 2 □ Cremation	3 □Removal from State	1		sition (Name natory or othe				0c. Location - Ci		n, State	
≣	it. Partmer		* 4 □ Donation 5 □ Other ( 21. Signature of Funeral Service		Fa		Cemete		11-26		Honduras			
Ba	Department of the control on the con		Monda C	· Bacon, cc	0361	/ 3	44/ 14	th Sti	reet, I	H. Bacon N.W. Wasi	nington,	DC T Ho	me Inc. 20010	
	Pnysician		Immediate Cause (Final disease or condition	st only one cause on each I	ne.		er the mode o orrhag		as cardiac o	r respiratory arres	st,	Ir O	pproximate iterval Between nset and Death days	
E	/Medical Examiner		resulting in death)	Due to (or as										
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Ur Jenying Cause (Disease or injury	b. Hyperi								-	years	
	cuted nd ransit	Examiner	that initiated events	C										
8760,	cate be executed by sician and the burial-transit		resulting in death) Last	Due to (or as	a consequer	nce of):								
687	physi s the b	dice		d.	-									
Box	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			<b>1</b> —				23d. Date o	f delivery		
P.O. B	res that the death signed by the atter be detached for	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1∐Live birth 4∏Pregnant a' 9☐ Unknown			Ectopic pregr Other <i>(specil</i>				Month	Da	y Year	
Vital Records, F	The law requires that the death certificate be execuled the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	by	Part II. Other significant condit	ions contributing to death b	ut not resultir	ng in the ur	derlying caus	e given in Pa	art I.		2 No 3		cause of death? y 4 □Unknow	ו
6C0	law re as bec 2 sho	Completed								24a. Was an autopsy	24b. Wei	e autopsy	findings availabl	9
		Com								performe	ed? dea	th?	etion)of cause of ∃No	
VIta V	sicien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?					Othor		(Check only one)		***		
0	Phys r this ral dir	1; To	1 Yes 2 No	1 ZNnpatie		Outpatien  b. Time of	3 ☐ DOA		-	ne 5 Residen 8d. Describe how		Specify)		
0	tth: : After e funei	tion	1 X Natural 5 ☐ Pendi	28a. Date of Inju ing (Month, Da iigation	y Year)	Injury		Injury at Work? 1 ☐ Yes 2		.50. 50001150 11011	injury occurred			
Division of	I or Attendate after death Director:	Certification;	3 Suicide 6 Could	not be 28e. Place of Inj building, et	ury - At home c. (Specify)	, farm, stre	et, factory, of	fice	2	8f. Location (Stre City or Town,	et and Number o State)	or Rural R	oute Number,	
	Hospita 4 hours Luneral ely fillec	edical Co	29a. Certifier 1 X Certifyi (Check only one) 2 Medical	ng Physician: To the best I Examiner: On the basis o and manner st	f examination	idge, death and/or inv	occurred at the estigation, in	ne time, date my opinion,	and place, a death occurre	nd due to the cau d at the time, dat	se(s) and manne e and place, and	er as state due to the	d. e cause(s)	
	To the h within 2 To the f complete	Me	29b. Signature and title of certific					cense numb	er		I. Date signed (M			-
^			Ayror	eryo	MD	)	- 6	1856		N	ovember	16,	2004	
R	(3)		30. Name and address of person Heather Lore	who completed cause of dinzo, $M.D.$	eath (Item 23	3a) (Type, 6 9901	Print) Medica	1 Cen	ter Dr	., Gait	hersburg	g, Md	. 20850	0
	Sta Registr		31. Date filed (Month, Day, Year NOV 1 8		ar's Signature	he	de)							

State of Maryland / Department of Health and Mental Hygiene 38201 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 8.47PM NON SMBEK 13,2004 Virginia C. Minnis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🖫 F Yrs 87 Director 057-16-1466 01 06 17 Fauguier Co. VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r 28a-f show 1 Yes 2 No Director MD Prince Georges Lanham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ other traumatic avant, I've Madical Examiner must be or Itams 23a 20706 USA Funeral 5407 Crescent Avenue death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specif Black 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Beautician 9th markad other t of Health and Mental Hy 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Pollard Andrew Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edward W. Minnis/Son 5407 Crescent Ave. Lanham, Md. 20706 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If is any injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Bemoval from State LAndover, MD. 11-20-04 Harmony Memorial ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses 23a. Part 1 There he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 4217 9th. St. N.W. Washington, D.C. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Due to (or as a consequence of): My /Medical resulting in death) **Examiner** Acute myoun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed METERIO SCENOTE They would and Due to (or as a consequence of): nding physician a use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atten for us 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has s certificate has lirector, page 2 Hyperupivemi 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 10 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 THO P 1 DOA 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death uneral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending within 24 hours after control to the Funaral Diractor: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier D 0016197 ward mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADD KES LALA M.D. Markey Michall MANAGE Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 7 2004 Registrar

			For State Registrar	State of Maryla		artment of H			giene ()	04	38202
			Decedent's Name (First, Middle, La.	st)		timodio or i	504111	2. Date of Dea			3. Time of Death
	Physicia		Hattie Parrott					Month	Day 14.	Year	3:3570M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea			nty of Death	-
	LAdiniii	CI	Doctor's Hospit			Lanham			Prin	ce Ge	nrge
	Funeral		5. Social Security Number 6. S	ex 7. Age (In vrs	. last birthday)	If Under 1 Year	If Under 24 Hr		h		place (State or Foreign intry)
	Director		220-14-0544	□M 2 <b>A</b> F 88	Yrs.	Months Days	Hours Min	n. (Month, Day Aug. 28			n Carolina
	2		Usual Residence of Decedent						, _ , _ ,	pouci	odioiina
	irylar ihow	_	10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Ba-f s	cto	Maryland Prince G	eorge Lai	ndover						12 Yes 2 □ No
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cou	intry?
	ath w	ra	1921 Belle Haven	Drive		20785				d Stat	tes
	r de s	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? ( in, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. F	Race - Ameri Black, White,	
36	be filed within 72 hours after death with the Maryland ital Hygiene. I have not other than "natural", or items 23e or 28e-f show event, the Medical Examinar must be motified at event,		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 No If Yes, Give		1 ☐ Yes 2🛣 No	Specify:		Spe	city: D.1	1
21215-0036	hour fural	Completed by	15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occupa	ation		16h Kind of	B1a f Business/Ir	
<u>τ</u>	in 72	let	(Specify only highest gra	ide completed)	(Give	kind of work done of NOT use retired	during most of w	orking	TOD. KING OF	Dusinessiii	idustry
72	with iene. ther	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		sperson	,		Priv	ate	
	filled Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)	)			18. Mother's Na	ame (First, Middle,			
Maryland	ld be ental ked ic ev	To B	Edward Parrott				Flore	nce Tone	ey .		
ary	shou nd M mar	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street a	and Number or F	Rural Route Numbe	r, City or Tox	vn, State, Zi	p Code)
	nd 2 alth a 27 is		Dorothy Miller-Me	lvin/ Daughter	r 3406	Edwards S	St. Spri	ngdale, 1	Maryla:	nd 207	774
re,	s 1 a of He item othe		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other plac	e)	Date	20c. Locatio	n - City or T	own, State
E	Page lent o nt: If ry or		1 ¬Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specifi	Hemoval from State		on Cemete		/20/04	Darlin	igton,	S.C.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at one.		21. Signatury of Funer VS / vice Licer	1590	s of Facility	e Funeral	Uomos				
m	88 1 8		I will a k	Mos	5	538 Marli	oro Pik	e Forest	ville,	Md. 2	20747
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory are	rest,		Approximate Interval Between
	Physician	6.1	Immediate Cause (Final disease or condition	A	Arry	Alunia					Onset and Death
	/Medical		resulting in death)	a. Acute Due to (or as a conse	quence of):	Tomice					1412012
L	Examiner		Consectable for sea more	Coveno		rtery 8	sease				42005.
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):	t					
	acute ind trans	Examiner	that initiated events	c							
Ö,	e exe sian a urial-	<u>M</u>	resulting in death) Last	Due to (or as a conse	quence of);						
8760,	icate be executed physician and s the burial-transit	dlcal		d	-						
φ	ertific ling p	0	IF FEMALE:	22- 11							
Box	ath c	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Fet	al death 3	Ectopic pregnancy				Date of deliv Month	ery Dav Year
0	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of a 9□Unknown	death 5∟	Other (specify)					,
<u>α</u>	that the ed by detac	F.	Part II. Other significant conditions of	ontributing to death but not re	sulting in the ur	nderlying cause give	en in Part I	23e. Did to	bacco use co	ontribute to t	he cause of death?
Vital Records,	sign d be	d by		•		, , , , , , , , , , , , , , , , , , , ,		1□Y	es 2□No	3 ☐ Prol	bably 4 □Unknown
Ö	w require	Completed	****					-			
360	has has	ם						24a. Was a autops perfor	sy	prior to co death?	opsy findings available empletion of cause of
e									2 No		2 □ No
Ĕ	ding Physician:  After this certification of the director.	Be	25. Was case referred to medical examiner?	Hospital:	<b></b>	Othe	ar.	eath (Check only or			
of	Phys r this ral di	. To	1 ☐ Yes 2 🛣 No  27. Manner of Death	1 ☐ Inpatient 2 ☐	ZER/Outpatien 28b. Time of	1 JUDON	4   Nursing	Home 5 Resid			fy)
Division	Attending Firdeath.  ector: After by the funera	tlon	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work	ເ?ົ Yes 2 ∐No	204. 200201.	ow injury coo	unog	
S	or Attencater death Director: in by the	flca	3 ☐ Suicide 6 ☐ Could not b		nome, farm, str			28f. Location (S	treet and Nur	mber or Rur	al Route Number.
2	after after Dire	Certification:	4 Homicide	building, etc. (Speci		,,		City or Tow	n, State)		·
	spita hours inerel y filled	alc	29a. Certifier 1 Certifying Ph	ysicien: To the best of my kn	owledge, death	occurred at the tim	e, date and plac	ce, and due to the c	ause(s) and i	manner as s	stated.
	To the Hospital or At within 24 hours after C To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Exemone)	niner: On the basis of examinand manner stated.	ation and/or inv	estigation, in my op	oinion, death occ	curred at the time, d	late and place	e, and due to	o the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	-		29c. License	number	2	9d. Date sign	ned (Month,	Day, Year)
•			Atrene	Reus MD		010	1446		11/13	5/04	
0	(10)		30. Name and address of person who						4.)		
				71500 14.0. 5		IN STREE!	7, 50/10	531,41	WE'LL	MO	20107
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Sign							
	····	4 1	NOV 1 7 2004	Bear &	400	1					

			For Stata Registrar	State of	Marylan		artment rtificate				ental Hy	giene Reg. No.!	2004	382	203
	Discontact		1. Decedent's Name (First, Middle	, Last)					-	1	2. Date of Dea Month		_	3. Time of	
П	Physici /Medio		Richard Franci	s Mahoney							Novemb			8:15	рм
	Examin		4a. Facility Name (If not institution	give street and num	ber)		4b. City, T	own, or	Location o	of Death		4c.	County of Death		
			Holy Cross Hos						Sprin				Montgom	ery	
	Funeral		5. Social Security Number	6. Sex 7 1 M 2 F	7. Age (In yrs. 81	• • •	If Under 1 Months	Days	If Under a	Min.	8. Date of Birt (Month, Day	y, Year)	Cou	place (State on try)	
	Director		Usual Residence of Decedent							Ī	April 9	, 192	23 Wash	ington	, DC
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Ci	ity Limits
	a-1 st	ctor	Maryland Montg	omery	Wh	eaton								1 🗌 Yes	2 🙀 No
	or 28	Directo	10e. Street and Number				10f. Zip C	Code				10g. Citiz	zen of What Cou	ntry?	
	23a	ral	11513 Galt Av	enue			209	902					USA		
	tems	Funeral	11. Marital Status	12. Was Deced	ces?	.S. 13. \	Was Decede f Yes, specif	ent of His by Cuban	panic Orig	gin? (Spec i, Puerto F	cify Yes or No- Rican, etc.)	. 1	<ol> <li>Race - Ameri Black, White,</li> </ol>		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced		2 No tes: 1942	-45	1 ☐ Yes 22	(XNo	Specify:				Specify: Wh	nite	
21215-0036	72 hours after death with the Maryland Insturel', or Items 23a or 28s-1 show disel Exerca or must be redified at	edi	15. Decedent		163. —		dent's Usual	Occupa	tion			16h Kir	nd of Business/In	ndustry	
212	nin 72 na na Media	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-	405 51	(Give	kind of work DO NOT use	done du	urina most	t of workin	g	.05		.ouotry	
21	d within giene.	Com	12	Conege (1	401 34)	Direc	tor of	Adı	minis	strat	ion	Vet	eran's A	dministr	ation
DG L	be filed ntal Hygir ed other event, I	Be (	17. Father's Name (First, Middle, I	.ast)							(First, Middle,	Maiden :	Sumame)		
yla	should bind Ment	Tof	Richard F. Mah	oney					Ma	ry J.	Endre	S			
Maryland	2 sho and Is m		19a. Informant's Name/Relationsh			19b. Mailir	g Address (	Street ai	nd Numbe	r or Rural	Route Numbe	r, City or	Town, State, Zip	Code)	
-5	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-4 show other traumatic event, the Medical Example at Innat be indifficial at		Adele M. Hook/	Daughter	205 0				r Co				MD 207		
Baltimore,	Ses 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from S	tate 200. P	Place of Dispo emetery, cren Gate	natory or oth	e or ner place aven	) N	ovemb	per 18		cation - City or To		
Ë	t. Pa			Donation 5 □ Other (Specify)  That of Juneral Service Licensee  20 Cemetery  22 Name and Address of Facility  Francis J. Collin									er Spri	ng, Ma	rylan
Ba	permit. Pages 1 Department of H Important: If iter any injury or ott		21. Signate of Juneral Service L	Jenses Co	le_	lins Blvd	Funera !, W, S	l Ho ilve	me Inc. r Sprin	g, MD	20901				
l.			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that ca only one cause on ea	used the death ch line.	h. Do not ent	er the mode	of dying	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Bety Onset and E	ween
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a. Resp	iratory	Failu	re							Onset and t	Jeath
	/Medical Examiner		resulting in death)	Due to (c	r as a conseq	uence of):									
		-	Sequentially list conditions,		stivo rasa consequ		Failu	re							
	nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underwing Cause (Disease or injury				. •								
Ć,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last		ilobar ras a consequ		nıa								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	dlcall		d											
9	tificate ng phys as the	ledi		1								- 1		-	
ŏ	death certifica attending phater use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna th 2 □ Fetal		Ectopic preg	nnancv				2	3d. Date of delive	-	
O. B	ed fo	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of de		Other (spec						Month	Day Y	'ear
<u>Ч</u>	res that the de signed by the a be detached t	Phy	9 Unknown												
	signer be d	þ	Part II. Other significant condition Chronic Obstru					ıse giver	n in Part I.				se contribute to the		
Ö	w require been si should b	eted	- CHIOHIC ODSCIU	ctive Puin	ionary	Diseas	e					es 2 [	]No 3∏Prob	ably 4 50	INKNOWN
Division of Vital Records,	: The law cate has b page 2 s	Completed									24a. Was a autops	sy	24b. Were auto prior to co death?	psy findings a mpletion of ca	available ause of
a F											1 Yes			2 No	
<u> </u>	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		-					Check onl or				- 17
ot	<u>a</u> ÷ <u>a</u>	. To	1 Yes 2X No 27. Manner of Death	28a. Date of	Injury	ER/Outpatien 28b. Time of		c. Injury	4∐Nur at		e 5 ☐ Reside Bd. Describe h		Other (Specification)	y)	
on	th. : After s funer	tlor	1X Natural 5 ☐ Pending 2 ☐ Accident investig	(Month	, Day Year)	Injury	м		? es 2∐N			,,			
/ISI	f or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could n	ot be 28e. Place of	of Injury - At ho	ome, farm, stre	eet, factory, o	office		28			Number or Rura	il Route Numi	ber,
ă	al or	Certification:	4 Homicide	buildin	g, etc. ( <i>Specit</i> )	/)					City or Town	n, State)			
	To the Hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by th	edical (	29a. Certifier Certifying (Check only one)	Physician: To the backaminer: On the backand manner	sis of examinal	wledge, death tion and/or inv	occurred at restigation, in	the time	o, date and nion, deat	d place, an	nd due to the c d at the time, d	ause(s) a ate and p	and manner as si place, and due to	tated. the cause(s)	
	omple	Me	29b. Signature and title of pertifier	A) A		)	29c. l	License	number		2	9d. Date	signed (Month,	Day, Year)	
1			· 611.	Al I.	100	7 111	D5	5226	1			Jouan	mber 14,	2004	
	10		30. Name and address of person v	no completed cause	of death (Item	1 23a) (Type. I	Print)					OVEI	WEL 14,	2004	
			Alan R. Segal,		Hugo		•	ver	Spri	ng,	MD 2090	6			
	Sta	-	31. Date filed (Month, Day, Year)	32. Re	giştrar's Signa	ture									
	Registr	ar	NOV 162	004 54	war	D	Spar	62/							

		ľ	For State Registrar	State of	Maryland .		artment of rtificate of		ınd Mental H	ygien.		38204
	Dhuoisi	on	1. Decedent's Name (First, Middle,						2. Date of I	Death		3. Time of Death
	Physici /Medic		KATHRYN	F	MILLER				NOVEMBI			
	Examin			IAL HOSPI			4b. City, Town, FREDERI	CK			EDERICK	
	Funeral Director		183-44-1898	. Sex 1 □ M 2 🔏 F	'. Age (In yrs. last	Yrs.	If Under 1 Yea Months Days		Min. 8. Date of E Month, Feb. 12	Birth Day, Year, 191		rthplace (State or Foreign Country) nsylvania
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Town or Lo	cation					10d. Inside City Limits
	Many I-f sh	tor	PA Bedfor	rd.	Ev	erett						1 ☐ Yes 🎞 No
	n the	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What C	Country?
	23a (23a ust b	ral	10202 Clearridge	Road			155	37			USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or othar traumatic evant, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed For	2 🔀 No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛣 No		jin? (Specify Yes or I , Puerto Rican, etc.)	No-	14. Race - Am Black, Wh Specify:	
5-0	72 ho	sted	15. Decedent's (Specify only highest		1	16a. Dece	dent's Usual Occu	pation	of working	16b. K	and of Busines	s/Industry
2	han "	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of work done DO NOT use retir	ed)	or working			
	Hygie ther t int, in	e Co	8 17. Father's Name (First, Middle, La	ist)		Qι	ilter	18 Mother	r's Name (First, Midd		Tourism	
Maryland	d be ental ked o c eva	To Be	David Walter Cos						flora Kath			
ary	shour od M mart	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Stree	L	r or Rural Route Num			Zip Code)
	and 2 latth a 127 ls		Helen Bennett/ I	aughter		3704	Lawson	Road.	Ijamsvill	e. MI	21754	
ore	of He of He fitem r oth		20a. Method of Disposition 1★ Burial 2 □ Cremation 3	Ü	0.000	e of Dispo	sition (Name of matory or other pla		Date		ocation - City o	r Town, State
Ě	Pages Iment of Itant: If ite		`4 □Donation 5 □Other (Spe		Pleas		Union Ce		1/15/2004			wnship, PA
Baltimore,	permit Depart Import any in 20029.		21. Signature of Funeral Service Li	Der					Stauffer on Pike, F			
F			23a. Part1/Enter the disease, or of shock, or heart failure. List or	mplications that ca	used the death. [ ch line.	Do not ent	er the mode of dy	ing, such as o	cardiac or respiratory	arrest,		Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition resulting in death)	a. Conb	237116	-	FIART	FAIC	IVRS			Onset and Death
	/Medical Examiner		resulting in death)	Due to (d	r as a consequen	ice of):						
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (c	r as a consequen	ice of):						
	d d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events									
o,	an an arial-tr	Exa	resulting in death) Last	Due to (c	r as a consequen	ice of):						
8760,	cate be executed physician and the burial-transit	dical	,	d								
9		Med	IF FEMALE:	00- 16								
Вох	it the death certifi by the attending tached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live bir	ome of pregnancy th 2 □ Fetal de nt at time of death	ath 3	Ectopic pregnand Other (specify)	у			23d. Date of de Month	Hivery Day Year
o.	the do	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknov		J_	Citiel (specily)					
S,	The law requires that the ste has been signed by the page 2 should be detached.	by PI	Part II. Other significant condition	s contributing to dea	ath but not resultin	ng in the u	nderlying cause g	ven in Part I.	23e. Dio	tobacco i	use contribute t	o the cause of death?
rds	w require been sig should b	ed t	ACUTE REN	AL FI	AILURE				10	Yes 2	□No 3□P	robably 4 X Unknown
Vital Record	e law re has be je 2 sho	Completed							24a. Wa	is an	24b. Were a	utopsy findings available completion of cause of
œ =		Com							per 1 Tes	formed?	death?	s 2 No
/ita	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?	11 2-1					of Death (Check only	one)		
of	S 0 =	2	1 Yes 2 No 27. Manner of Death	Hospital: In		Outpatien	1 JU DOA		sing Home 5 Re	-		ecify)
	ding h. After fune	tion	1 ■ Natural 5 □ Pending	(Month	, Day Year)	Injury		myat ork? ]Yes 2 □ N	28d. Describe	now inju	y occurred	
Division	Attending r death. sctor: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could no	be 28e. Place of	of Injury - At home	, farm, str			26f. Location			ural Route Number,
ā	al or s afte	Cert	4  Homicide	buildin	g, etc. (Specify)				City or I	own, State	)	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier Check only one) 1 Certifying 2 Medical Ex	Physician: To the bas aminer: On the bas and manne	sis of examination	dge, death and/or inv	occurred at the trestigation, in my	ime, date and opinion, death	place, and due to the occurred at the time	e cause(s) e, date and	and manner a d place, and du	s stated. e to the cause(s)
	To t To tl	M	29b. Signature and title of certifier					se number			te signed (Mon	,
)			Jahr Verm	7			D.	5779	6	No	rember	12, 2004
	2		30. Name and address of person wh					D 1	ial MD 01	701		
	Sta	to.	Lalit Verm. 31. Date filed (Month, Day, Year)		0 West 7 gist <b>ya</b> r's Signature	•	reet,	reaer	ick, MD 21	/ / / 1		
恢	Registr		NOV 1	7 2004	Beneva	/	O Sp	als	, ,			

			1 - For Amend Item	10d per FH	aryland 6Pep Ce	artment of t 72003 and rtificate of	dealth and Death	Mental Hyg	iene 0	04	38205
		Į.I	1. Decedent's Name (First, Middle, La	ist)				2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		Helen Clare	Prye				11	_23	2004	8:15a.m
	Examir	ıęr	4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, o	r Location of De	ath	4c. Count	y of Death	
		有	Southern Maryl			Clin		re la Data d'Eist		nce G	
	Funeral Director		,	Sex 7.Ag 1 □ M 2 🖾 F	e (In yrs. last birthday 78 Yrs.	Months Days	Hours Mi	n. (Month, Day,	Year)	Cour	
			189-20-7420 Usual Residence of Decedent		70			11-24	<del>-</del> 1926	P	<u>ennsylvania</u>
	yland now		10a. State 10b. County	-	10c. City, Town or L	ocation				1	0d. Inside City Limits
	Man-1-a	tor	MD Saint	Marvs	Great N	lills					1 ☐ Yes 2X No
	h the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cour	itry?
	72 hours after death with the Maryland natural', or itams 23a or 28e-f ahow dical Examiner must be naillied at		22049 Caravel	Court		206	34		Uni	ted S	tates
	ams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No- erto Rican, etc.)		ce - Americ	
98	or it		1 Never Married 2 Married	1 ☐ Yes 2 ☑ I If Yes, Give		1 ☐ Yes 2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Speci		
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						<u>W</u>	hite
21215-0036	be filed within 72 hours after death with the Marylan hat Hyglene. nd othar then "natural", or itams 23a or 28e-1 ahow avent. The Medical Examiner must be notilised at	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w	rorking	16b. Kind of E	Business/Ind	dustry
12	within ene.	шc	Elementary/Secondary (0-12)	College (1-4or 5	i+)		ered Nur	-60		Healt	h Care
	filed Hygi othar	e C	17. Father's Name (First, Middle, Last			Regise		ame (First, Middle, M			n care
an	ld be ental ked o	To B	Albert Jor	105			F1122	beth Hern	Δ		
Maryland	12 should be filed within h and Mental Hygiene. 7 ia marked othar then " traumatic avent, It a Mas	-	19a. Informant's Name/Relationship		19b. Mail	ng Address (Street		Rural Route Number,		, State, Zip	Code)
	2 = N L		William Prye, Sr	. / Husbar	d	Р	O. Box	97 Lexing	ton Pa	rk. M	D 20653
Je,	ges 1 ar t of Hea If itam or other		20a. Method of Disposition		20b. Place of Disp				20c. Location		
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	. !	-28-2004	Levin	ot on	Park MD			
alti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	nsee	_ 2	en Memori 2. Name and Addre	ss of Facility	Brinsfield	Funer	al Ho	me, P.A.
0	8 8 1 8		David A. Gof:					d. Leonard		Mary1	and 20650
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	no cations that cause the cause on each li	the death. Do not en	ter the mode of dyir	ng, such as card	ac or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A	E CUPO						Onset and Death
	/Medical		resulting in death)		a consequence of):		7 1 12 10 1				
п	Examiner	_	Sequentially list conditions,	PARK	THMIA	*					
	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):						
_	and I-tran	хап	that initiated events resulting in death) Last		a consequence of):	FAILU	RE			-	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-fransit			124-11	CONDAL	EFFL	13 4 52				
687	ficate phys s the	edical		d		1 1 1	. , , ,				
Box (	eath certific attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Da	ate of delive	rv
ă	death atte	Physician/M	in the past 12 months?	1 □Live birth 4□Pregnant at		□Ectopic pregnancy □ Other (specify) _	<i>'</i>				Day Year
0	at the de by the	nysi	9 Unknown	9□ Unknown							
σ,	res that igned b		Part II. Other significant conditions	contributing to death b	ut not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use con	tribute to th	e cause of death?
rds	w require been sig should b	pe p	ATRIAL HIB	RILATION	>			1 □ Ye	s 2 🗆 No	3 Prob	ably Winknown
Vital Records,	s bae	Completed by						24a. Was ar	n 24b.	Were autor	osy findings available
R	The lav te has age 2	mo						autops perform 1 Yes 2	ned?	prior to cor death? 1 \( \subseteq \text{Yes}	npletion of cause of
ta		a	25. Was case referred to medical				26. Place of D	eath (Check only on		1 1 1 1 1 1 1 1	20140
-		O B	examiner? Yes 2 \sum No	Hospital:	int 2 ER/Outpatie	nt 3 DOA Oth		Home 5 ☐ Reside		ner (Specify	')
ı of	P + P	T : U	27. Janner of Death	28a. Date of Inju (Month, Da	ry 28b. Time o		v at	28d. Describe ho			
Ö	uttending I death. ctor: After y the funer	atlo	1 Accident 5 Pending investigation	in	, , , , , , , , , , , , , , , , , , , ,		Yes 2 □ No				
Division	or Attendater death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, farm, st	reet, factory, office		28f. Location (Str City or Town		ber or Rura	l Route Number,
	ital or A	Cer		A .				H			
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the funer	edical	(Check only 2 Medical Exa	hysician: To the best miner: On the basis o	examination and/or in	h occurred at the tire vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, da	use(s) and mate and place,	anner as st	ated. the cause(s)
	the tha	Med	one)	and manner sta	ited.	29c. Licens	e number	20	Pd. Data signs	d /Month I	Day Voss)
<b>.</b>	2		29b. Signature and title of certifier					28	d. Date signe	e (month, t	ruy, rous)
7	SAG			Ja Latera	m29~		689.	$\epsilon$	9 11	124	2004
	- 0		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type OYTH RON	Print)	D HOLDY	TAL CENT	TE2	7507	SURRATTIR
	Sta	eta.	31. Date filed (Month, Day Year)	32. Regist	r's Signature	CLINT	W MD	20735	G 10 Tab		SURRATTIR
	Registi		WOV 2	9 2004	r's Signature	Boselle					

			1- For State of Maryland / [		artmen						0.0	1,	382	206
			Decedent's Name (First, Middle, Last)						2. Date of De				3. Time o	
	Physici /Medic		MILDRED A. PLUMHOFF						NOV.	23	200	ear 4	8:20	) P M
0	Examin	er	4a. Facility Name (If not institution, give street and number)		•		Location o			1	County of		CTTV	
	Funeral		WESLEY HOME 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	rthday)	If Under		ORE C	1 Y 24 Hrs.	8. Date of Bir		LTIMO			or Foreign
A.	Director		10M 205	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Feb. 2,	". <b>"1</b> 9"1	.4	Couin MARY	lace (State try) LAND	
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow	vn or Lc	cation					-		1	0d. Inside C	City Limits
	Manyk f sho	tor	Maryland Baltimore City			imor	e Cit	у						s 2 □ No
	n 28a	rec	10e. Street and Number		10f. Zip	Code				-	zen of Wha	at Coun	try?	
	ath wil	ralD	2211 W. Rogers Avenue				212				JSA			
	er de:	une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No	13. \	Was Deced f Yes, spec	lent of Hi ify Cuba	spanic Ori n, Mexican	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	- 1	14. Race - Black, '	Americ White,		
036	urs aft al', or Exam	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 □ Yes 2	<sup>2</sup> √ <sub>No</sub>	Specify:				Specify: V	Whit	e	
21215-0036	within 72 hours after death with the Maryland sne han "natural", or llems 23a or 28a-f show ha Medical Examinar must be notified at	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usua kind of wor	k done d	lurina most	t of work	ing	16b. Kir	nd of Busin	ness/Inc	lustry	
121	within ane. than	mpl	Elementary/Secondary (0-12) College (1-4or 5+)		ponorus sewife		) -			Hous	ekeer	pino	ı~0wn	Home
<u>ф</u>	Hygie other ent,	Be Co	10th grade N/A 17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	e (First, Middle,		<u>'</u>			
/lan	uld be Wental Irked	To B	James A. Everett				Mami	e E.	Jones					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show emportant: If item 27 is marked other than "natural; or Items 23a or 28a-f show appring yor other traumatic event, the Medical Examinat must be notified at once.		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Carol A. King (Daughter)						al Route Numbe Walnut					
ē,	tem 2		20a. Method of Disposition 2 Democratics 3 Democratics State			_		30.00	Date		cation - Cit			
Ë	Pages nent of int: If i		1 Burial 2 □Cremation 3 □Removal from State  1 □ Donation 5 □ Other (Specify)  1 □ Donation 5 □ Other (Specify)					1-29	0~04	Balt	imore	e, N	1d.	
Baltimore,	permit. Departminents imports eny inju		21. Signature of Funeral Service Licensee	22	. Name an	d Addres	s of Facilit	у но	me 740	l Be	lair	Rd.		
ш	20599	( (	E. J. Jassah						Bal		ore, N	Md.	21236	
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final					01		rrest,			Approxima Interval Bei Onset and	tween
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence		VASC	ULAI	C /	ccu	DENT			+	DAY-	ζ.
	Examiner		CHREBROVASCIN	,	DIS	GAS	E - E	ND	STAGE	2			YEAR	2.5
7	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ŕ					. Dise				110.0	
	xecute n and al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  c. ARTRIOSCLINO:  Due to (or as a consequence	71 C of):	CAR	010	ASCU	LAR	DISE	nst			YEAR	٦
8760,	cate be executed physician and the burial-transit	cal E	d											
89	ntifical ing phy s as th	Medi	IF FEMALE:											
Вох 6	leath certific attending p	ian/l	23b. Was decedent pregnant in the past 12 months?		Ectopic pro					2	3d. Date of Month		,	Year
P.O.	the de y the	Physician/Med	1 ☐ Yes 2 🕱 No 4 ☐ Pregnant at time or death 9 ☐ Unknown	3	J Other (spi									
S, D	vrequires that the de been signed by the s should be detached	by PI	Part II. Other significant conditions contributing to death but not resulting in	in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	obacco us	se contribu	ute to th	e cause of	death?
ord	w require been si should t	ted	MULTI-INFARCT DEMENTIA; REEN	AL	[AIL	URE	•		1 🗆 ነ	∕es 2[	]No 3[	☐ Proba	ibly 4	Unknown
3ec	has b	Completed							24a. Was autop perfo	sy	24b. Wer prior deat	r to con	sy findings apletion of c	available cause of
al	n: Th ficate or, pag		25. Was case referred to medical				00 Pl	-4 Da - N	1 ☐ Yes	2 No			2□ No	
⋚	ysicia is certi directo	To Be	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Ou	utpatien	t 3 DO	A Othe	. 0.		n <i>(Check only o</i> me 5 🗆 Resid		□Other (	(Specify	)	
Division of Vital Records,	ng Ph fter th meral			Time of Injury	2	Bc. Injury Work			28d. Describe h					
<u>sic</u>	ttendi death. stor: A	icatl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	arm etr	M eet factory		/es 2 □ I		28f. Location (5	Street and	Number	or Bural	Route Nun	nhor
Θ	after after Direct In by	Certification;	4 Homicide determined 209. Place of injury A(Tionis, la	arm, Sm	eet, lactory	, once			City or Tou		/vuiliber (	ur nurai	HOUSE NUS	iber,
,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier Certifying Physician: To the best of my knowledge (Check only Decirion 2 Medical Examiner: On the basis of examination an											s)
	thin 24	Medi	one) and manner stated.  29b. Signature and sittle of certifier ,				number				signed (A			,
	Z .3 Z 8		I Stoke JE VShahrD.				942	5		11	1201	/5,	14	
	3		30. Name and address of person who completed cause of death (Item 23a)	(Type,					-	11/	27/	20	10 /	-
				1. R	OGER.	s A	VE -	B	ALTIMO	RE,	MD	2	120	1
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	6	So	ak				,				

			1 - For State Registrar	State of Mar	yland / Depa <i>Ce</i>	artment <i>rtificate</i>	of H	ealth ar Death	nd Me		ene ()	04	38207		
	Physici		Decedent's Name (First, Middle, Last,     VINCENT	JOHN	DACCI	III I O			1	2. Date of Death Month	Day	Year	3. Time of Death  8:52 A M		
	/Medio Examir		4a. Facility Name (If not institution, give		PASCI		Town, or	Location of	Death	, 1	4c. Coun	ty of Deeth	0 30/1		
W		45	Atlantic Genera				lir				Wor	çest	er		
	Funeral Director		5. Social Security Number 6. Security Number 196-24-6007	7. Age (I	n yrs. last birthday)	If Under 1 Months	Days	If Under 24 Hours	Min.	3. Date of Birth (Month, Day, 6-26-3	y, Year) Country)				
	yland yland		10a. State 10b. County	10	Oc. City, Town or Lo	ocation							10d. Inside City Limits		
	Ba-f si	ctor	MD Worcest	er	Ocean	City							1 ☐ Yes 2 Mo		
	with ti	Funeral Director	10e. Street and Number 10223 Bent Cree	בת -		10f. Zip (				10	g. Citizen o	f What Cou	ntry?		
	death ms 23	era		12. Was Decedent Eve	er in U.S. 13.		. 842 ent of His		n? (Speci	ifv Yes or No-	USA 14. Ra	ace - Ameri	can Indian,		
920	72 hours after death with the Maryland 'natural', or Items 23a or 28s-f show dissal Examinar must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates:5 1		If Yes, speci 1 ☐ Yes 2,		Specify:	Puèrto Ri	ify Yes or No- can, etc.)		ack, White,			
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual kind of work	Occupa done d	ition urina most o	of working	, 1	6b. Kind of				
121	ed within rgiene. er then	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)					O			
d 2	filed Hygie other	e)	12 17. Father's Name (First, Middle, Last)			Eng	ine		s Name (	First, Middle, M			rnment		
Maryland	2 should be and Mental is marked o	To B	Elmer Pasciul	lo					nnie						
lar	2 sho and h is ma		19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailir	ng Address (	Street a			Route Number,		n, State, Zip	Code)		
Baltimore, N	es 1 and of Health item 27 r other t		Anita S. Pasciu  20a Method of Disposition  1 Program 2 Cremation 3 CR	•	use 102 20b. Place of Dispo cemetery, crer	sition (Name	e of		k Ed		n Ci				
Ħ	permit. Pages Department of Important: If it any injury or o		`4 ☐ Donation 5 ☐ Other (Specify)		Sunset				c 11	-22 E	erli	n, Mo	3.		
Ba	permi Depa Impo any ir		21. Signature of Juneral Service Licens			. Name and		,							
	T. F. ()		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	death. Do not ent	er the mode	of dying	unera , such as ca	rdiac or r	ome Frespiratory arres	erli	n, Mc	Approximate		
	Physician		Immediate Cause (Final disease or condition		umo	210							Onset and Death		
-mi	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):								, week		
2	9	0	Sequentially list conditions, in an Isaacra to modulate cause. Enter Underlying	Due to for as a co	insequence off:										
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									- 1			
ó,	cate be executed obysicien and the burial-transit	Exa	resulting in death) Last	Due to (or as a co	onsequence of);										
8760,	cate b	dica	d									•			
Box 6	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p	pregnancy						224 D	ato of doline			
P.O. Bo	The law requires that the death certific tte has been signed by the attending p vage 2 should be detached for use as t	Physician/Medical	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 2□ 4□Pregnant at tim 9□Unknown			ther (specify)					23d. Date of delivery  Month Day Year			
ω, σ	res that igned b be deta	by Pi	Part II. Other significant conditions con	tributing to death but n	ot resulting in the ur	nderlying cau	ıse givei	n in Part I.		23e. Did toba	cco use con	tribute to th	ne cause of death?		
ğ	w require been sig should b									1 ☐ Yes	2 1 No	3 🗆 Prob	ably 4 □Unknown		
		Completed							_	24a. Was an autopsy performe 1 \(\sum \) Yes 2		prior to cor death?	psy findings available inpletion of cause of		
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						Death /	Check only one)					
	Phys this aldi	2	1 ☐ Yes 2 No H	ospital: 1 Inpatient	2 ☐ ER/Outpatien 28b. Time of			4 🗀 Nursi	-	5 Residen			/)		
on	ding I th. : After s funer	tlon	1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	par) Injury	M	C. Injury : Work?	ai P es 2∐No		d. Describe how	injury occur	rred			
Division of	I or Attend after death Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, stre Specify)	et, factory,	office		28f	. Location (Stre City or Town,		ber or Rura	l Route Number,		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) Certifying Phys	ician: To the best of m er: On the basis of exa and manner stated.	amination and/or inv	occurred at restigation, ir	the time	, date and p nion, death o	place, and occurred	due to the cau at the time, date	se(s) and m a and place,	anner as stand due to	ated. the cause(s)		
	To the To the complet	Me	29b. Signature and title of certifier	/ ,		29c. i	License	number		290	. Date signe	ed (Month, L	Day, Year)		
			1 clip	- phy	51611	H	44	283			11/16/	2004			
Li	144.1	luj.	30. Name and address of person who co		4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		-01	CHIE A		18/-		/			
	Sta	e	TOBERT DU IN DO  31. Date filed (Month, Day, Year)	9133 191 32. <b>Be</b> gistrar's	ACTHWN Signature	OK P	KL	111 N	UJ S	104					
(2)	Registra	ar	31. Date filed (Month, Day, Year) 7 20	U4 Brown	J. J.										

rASCIULLO, UINEAT

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

**Funeral Director** 

Be Completed by

2

Examiner

by Physician/Medical

Be Completed

Medical Certification; To

31. Date filed (Month, Day, Year) NOV 1 6 2004

r this certificate has been signed by the ral director, page 2 should be detached

State Registrar		Cei	artment of F			. No. 🔿 🔿 🔿	
Decedent's Name (First, Middle, Las	st)				2. Date of Death	200	3 Jimelot Beatth
Klara Nordenho	oltz Pentz				Month	13 a0	04 08 10 AM
Facility Name (If not institution, give he Memorial	Hospital at	EASTON	4b. City, Town, o	Location of Death		4c. County of D	bo+
Social Security Number 6. S 6. S 1	ex 7. Age (In ☐ M 2 🛣 96	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 12-08-		Birthplace (State or Foreign Country) Baltimore, I
a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
MD Talbo		Easton					1 Yes 2 No
e. Street and Number			10f. Zip Code		106	g. Citizen of What	
501 Dutchmans	Tana A-+	101					,
. Marital Status	Lane Apt.	in U.S.   13. \	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-		American Indian,
1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	if Yes, specify Cuba 1 ☐ Yes 2 <b>X</b> No	Specify:	o Rican, etc.)	Black, W Specify: W	Vhite, etc. Vhite
15. Decedent's Ec	Jucation	16a. Deced	dent's Usual Occup	ation during most of wor	kina 16	6b. Kind of Busine	ess/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retired			C M:1:+	227
Father's Name (First, Middle, Last)		Sten	ographe		ne (First, Middle, Ma	S Milit	ary
Frederick Nor					Geiser	uden Sumame)	
a. Informant's Name/Relationship		19h Mailir	nn Address (Street	and Number or Ru	ral Route Number, (	City or Town Stat	te Zin Code)
Julie Bamblin					Easton,		
. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	-	natory or other plac	1	Date 2004	Dover,	
pa. Part 1. Enter the disease, or com shock, or heart failure. List only mediate Cause (Final sease or condition sulting in death)  equentially list conditions, any, leading to immediate use. Enter Underlying use (Disease or injury at initiated events sulting in death) Last	plications that roused the one cause on each line.  a	nsequence of):	1.	s, 518 St g, such as cardiac XACON	1.0	* .	Approximate Interval Between Onset and Death Oncy S
	d					204 Day 4	
	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnan <i>c</i> y Other (specify)			23d. Date of Month	delivery Day Year
1 ☐ Yes 2 No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown  contributing to death but no	Fetal death 3 Coordeath 5 C	Other (specify)		23e. Did toba 1 ∐ Yes	Month	
b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown  contributing to death but no	Fetal death 3 Coordinates of death 5 Coordinates of the unit resulting in the unit resul	Other (specify)		1 ☐ Yes 24a. Was an autopsy performe	Month  cco use contribut  No 3  24b. Were prior	Day Year  e to the cause of death?  Probably 4 Unknown  autopsy findings available to completion of cause of 1?
o. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  II. Other significant conditions of the conditi	1 Live birth 2 Live birth 4 Pregnant at time 9 Unknown contributing to death but no	Fetal death 3 C of death 5 C	Other (specify)	en in Part I.	1 Yes  24a. Was an autopsy performe 1 Yes 2 th (Check only one)	Month  cco use contribut  24b, Were prior deatt	Day Year  to the cause of death?  Probably 4 Dunknown  autopsy findings available to completion of cause of 12  Yes 2 No
b. Was decedent pregnant in the past 12 months? 1	1 Live birth 2 Liv	Fetal death 3 Control of death 5 Control of death 6	other (specify)  Inderlying cause give  at 3 DOA Other  28c. Injur  Wor  M 1	an in Part I.  26. Place of Dea	24a. Was an autopsy performe 1 Yes 2 Cth (Check only one) ome 5 Resident 28d. Describe how	Month  cco use contribut  24b. Were prior death Ano 1 1 1	Day Year  e to the cause of death?  Probably 4 □Unknown  autopsy findings available to completion of cause of 1?  Yes 2 □ No  Specify)
Was case referred to medical examiner?  Was case referred to medical examiner?  Manner of Death	Hospital:  2   All Pregnant at time 9   Unknown    2   All Pregnant at time 9   Unknown    3   All Pregnant at time 9   Unknown    4   Pregnant at time 9   Unknown    4   Pregnant at time 9   Unknown    5   All Pregnant at time 2    4   Pregnant at time 2    5   Pregnant at time 2    6   Pregnant at time 2    6   Pregnant at time 2    6   Pregnant at time 2    6   Pregnant at time 2    7   Pregnant at time 2    8   Pregnant at time 2    8   Pregnant at time 2    8   Pregnant at time 2    8   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at time 2    9   Pregnant at tim	Fetal death 3 Control of death 5 Control of death 6	other (specify)  Inderlying cause give  at 3 DOA Other  28c. Injur  Wor  M 1	26. Place of Dea ar: 4 Nursing H	24a. Was an autopsy performe 1 Yes 2 Cth (Check only one) ome 5 Resident 28d. Describe how	Month  cco use contribut  2 No 3   24b. Were prior deatt  No 1   cce 6 Other (S	Day Year  to the cause of death?  Probably 4 Dunknown  autopsy findings available to completion of cause of 12  Yes 2 No

State Registrar

DHMH 17 Rev 1/2001

Michael J. Fisher, MD 511 Idlewild Ave., Easton, Md. 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			_ For	State of Maryland	/ Depa		ealth and l	Mental Hygi	ene 21	004	20200
			1 State Registrar  1. Decedent's Name (First, Middle, Last)			uncate of L	realli	2. Date of Death	J. No. 5		3. Time of Death
	Physicia	ın	_					Month November	Day	Year	M
	/Medic		Lugene Pittman  4a. Facility Name (If not institution, give st			4b. City. Town, or I	ocation of Dogt	12 4c. County		1630	
	Examin	er				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1			
	· · · · · · · ·		Prince George's  5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year	heverly If Under 24 Hrs.	8. Date of Birth		9 Birtholac	eorge's
	Funeral Director			M 2CXF 56	Yrs.	Months Days	Hours Min.	Oct. 24.			e (State or Foreign Carolina
			Usual Residence of Decedent					OCL . 24,	1940	NOTEH	Carornia
	how	,	10a. State 10b. County	10c. City, T	own or Lo	cation				10d.	Inside City Limits
	a-f.s	cto	Maryland Prince G	eorge's		Capit	ol Heig	hts			1 X Yes 2 No
	or 28	Director	10e. Street and Number	0		10f. Zip Code	J		g. Citizen of \	What Country	?
	ours after death with the Maryland ral', or Items 23a or 28a-f show Examiner must be notified at	ai	508 Shady Gle	n Drive			20743			ed Sta	
		Funerai		<ol><li>Was Decedent Ever in U.S. Armed Forces?</li></ol>	13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (S , Mexican, Puerl	pecify Yes or No- o Rican, etc.)		ce - American ck, White, etc.	
30	or I	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give	1	☐ Yes 2 No	Specify:		Specify	y: Bla	ck
9500-61212	filed within 72 hours after Hygiene. Ither than "natural", or Ite snt, the Medical Examine		3 ☐ Widowed 4 ₹ Divorced  15. Decedent's Educ	Year or Dates:	Go Doord	ent's Usual Occupat	ine	1.41	Ch Kind of B	usiness/Indus	
ည်	i within 72 ho jiene. r than "natur the Medical	Completed	(Specify only highest grade	completed)	(Give	kind of work done du OO NOT use retired)	iring most of wo	rking	DD. KING OF B	25 Ind 25/111002	uy
7	withi ene. than	шс	Elementary/Secondary (0-12)	College (1-4or 5+)	Soor	etary-Hom	oland C	oouri tu	C	overnm	ont
D D	be filed ital Hygir d other event, I		17. Father's Name (First, Middle, Last)		DECI			ne (First, Middle, Ma			ent
<u>a</u>		To Be	Emerson P	ittman				Sara	n Park	er	
Maryland	d 2 should th and Men 7 is marks traumatic	-	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street ar	nd Number or Ru	ıral Route Number,			nde)
	12 7 In 8		Sarah L. Pitt - S	ister	508	Shady G1	en Dr.,	Capitol 1	Height	s, MD	20743
ē,	ーゴるち		20a. Method of Disposition	20b. Place	of Dispos	sition (Name of natory or other place	im	Date 20	oc. Location -	City or Town	, State
Ë	age ent o nt: if y or		1 Burial 2 Cremation 3 Re  1 4 Donation 5 Other (Specify)	miloval ilolli State		Bapt. Ch.		16/2004	Whita	kers,	NC.
Baltimore,	permit. F Departmo Importar eny injur	1	21. Signature of Funeral Service License					tewart Fu			
ñ	Deg Time		De la Sta	was III				., N.E. W			19
н			23a. Part . Inter the disease, or complice shorts, in heart failure. List only one	ations that caused the death. I	Do not ente	er the mode of dying,	, such as cardiad	or respiratory arres	it,	Ar	oproximate terval Between
	Physician		Immediate Cause (Final	Hepatic Fa						Or	nset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequen						_	
1440	Examiner			Metastatic	Brea	st Cancer					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequen-	ea of):						
	cuted nd ransi	Examiner	that initiated events								X
Ď,	te be executed ysician and he burial-transit		resulting in death) Last	Due to (or as a consequen	ce of):						
3/60	ate be nysici	Icai	d.							1000000	
9	law requires that the death certificate I as been signed by the attending physis should be detached for use as the i	Physician/Med	IF FEMALE:						1		
X Q Q	ith ce itendi	an/l	23b. Was decedent pregnant in the past 12 months?	Ic. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregnancy			1	te of delivery onth Da	y Year
	e des the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	າ 5⊡	Other (specify)			1010	nui Da	y roar
J Ö	res that the designed by the a	Phy	Part II. Other significant conditions cont	tribution to doubt but not condition	o in the con-	dark in a cause ause	in Dard I	22a Did taha	200 1100 2001	ributa ta tha d	ause of death?
Š,	res th	by	Hyper Calcae		ig in the ur	idenying cause giver	ili Falti.				y 4 Unknown
5	w require been sig should b	eted							2 140	3 1 TODADI	y + Conknown
ec	alaw asb	Completed	Hepato Rena	Syndrome				24a. Was an autopsy		prior to compli	findings available etion of cause of
=	The cate har page	Co						performe 1 ☐ Yes 25	od? ₹No	death? 1 □ Yes 2 □	□ No
Vital Records,	Attending Physician: The law ir death. ector: Alter this certificate has b by the funeral director, page 2 s	Be	25. Was case referred to medical examiner?	aceital:				ath (Check only one)			
	ک ≅ ک	5	TE TOS ZIXINO	-	Outpatien		4   Nursing H	lome 5 Residen			
ב	ling I	ion	27. Manner of Death 1  Natural 5  Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c, Injury : Work? M 1 7	es 2 No	28d. Describe how	injury occur	ed	
<u> </u>	death death tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	farm etr		92 5 140	28f. Location (Stre	et and Numb	or or Pural P	outo Numbor
Division of	2 1 1 2	Certification;	4 Homicide determined	building, etc. (Specify)	, iaiii, stie	et, ractory, office		City or Town,		er or nurar no	oute Number,
	e Hospital (1744 hours al e Funeral Dietely filled i		29a. Certifier 1X Certifying Physi	ician: To the best of my knowle	dge death	occurred at the lime	date and place	and due to the cau	se(s) and ma	nnor as state	d
	24 hos Fun etely	Medical	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	and/or inv	estigation, in my opi	nion, death occu	rred at the time, dat	e and place,	and due to the	e cause(s)
	Yo the Hosyithin 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. License	number	290	d. Date signe	d (Month, Day	, Year)
	[ s - o		1 Home to	1ado MD		921	883		11/13	04	
/	6/00		30. Name and address of person who cor	noleted cause of death (Item 23	la) (Tvne				t I		
1	Jy C		Hema Yadla,				Lanham	Seabrook	, MD	20706	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature							
	Registr		NOV 1 7 2004	en It Som	E)						

Physician	
/Medical	
Examiner	

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Marticul Exerter or rural to confide

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To tha Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Diractor: After this certificate has baan signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans

Division of Vital Records, P.O. Box 68760,

1 - For State Regist	trar	State of I	Maryland / I	Depa <i>Cer</i>	artment <i>tificate</i>	of H	ealth : Death	and N		gien Reg. N	man and an	4	382	10	
	nt's Name (First, Mid	<sub>dle, Last)</sub> tor Manuel V	icente P	erez	Z				2. Date of De Month Novemb	ath D	ay	Year	3. Time of	Death M	
	Name (If not instituti	on, give street and numb			4b. City, T	own, or	Location	of Death	noveni	4	c. County			<u>A</u>	
	cban Hospi ecurity Number	Age (In yrs. last bi	irthday) Yrs.	Beth If Under 1 Months		a If Under 24 Hrs. Hours Min.		8. Date of Bir (Month, Da	th ly, Yea	Montgor		Mery Birthplace (State or Fo Country) <b>Luatemala</b>			
	dence of Decedent	h	10c. City, Tow		cation				иолешре	21 2	4,	, .	10d. Inside Cit		
		ntgomery			ersbur	g				1 X Yes 2 □ No					
10e. Street	and Number	I. D 1.	100		10f. Zip (		70			- 10	itizen of V		•		
11. Marital	Status	12. Was Decede	ent Ever in U.S. es?	13. V	Was Decede	208	spanic Or	rigin? (Sp	ecify Yes or No Rican, etc.)				can Indian,		
1 <b>Z</b> Nev	ver Married 2 ☐ Ma dowed 4 ☐ Divorce	arried 1 Tyes 2	ZANO s:		Yes 2		Specify	:			Specify		panish		
Element	(Specify only high	ent's Education lest grade completed)  College (1-4	or 5+)	(Give life. [	dent's Usual kind of work DO NOT use	done d retired)	uring mos		ing	16b.	Kind of Bu				
8th	ary/Secondary (0-12) grade	Cons	struct	ion			o /First thinds	Maida	Cons		tion				
17. Father's Name (First, Middle, Last)  Regino Vicente Delgado  18. Mother's Name (First, Middle, Maiden Surmame)  Benigna Micaela Perez												-	driauez	7.	
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)															
Mario Vicente Perez (Brother) 409 Muddy Branch Road; Gaithersburg, Maryland 2087														2087	
1 <b>₹</b> Bu	od of Disposition urial 2 Cremation onation 5 Other	3 □Removal from Sta	ite	ary, cren	sition (Name natory or oth	er place			Date 26,2004	Sar	ı Jua	n Os	own, State tuncalo	20,	
	ure of Funeral Service		ell.	22	Name and	Addres	s of Facili		ios Sei	cvic		0-2-11/02/	7-101 Barasa		
Sequential if any, lead Cause (Distant inflate	shock, or heart failure. List only one cause on each line.  Interval Betwee Onset and Deal disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. This run arthin. Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):														
IF FEMALE 23b. Was on in the 1 Ty 9 Tu	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										23d. Date of delivery Month Day Year				
Part II. Oth	er significant condi	itions contributing to deal	h but not resulting	in the ur	nderlying ca	use give	n in Part	f	23e. Did t		obacco use contribute to the cause of death?  'es 2   No 3 Probably 4 □Unknown				
IF FEMALE 23b. Was c in the 1 year II. Oth									24a. Was autoj perfo 1 X Yes	an osy ormed? 2 \( \sqrt{N}	, c	Vere auto prior to co leath? X Yes	opsy findings a impletion of ca	ivailable luse of	
25. Was ca examin	ase referred to medic ner? es 2 \(\sum \) No	Hospital:	atient 2□ER/O	utpatien	it 3 DOA	Othe	r		h <i>(Check only o</i> nme 5 ☐ Resi		6 DOth	ar (Specif	f <sub>(c)</sub>		
- 1171	r of Death itural 5 Pend	28a. Date of	njury 28b.	Time of Injury	28	c. Injury Work			28d. Describe	how inj	ury occurr		1		
27. Mannei 1	uicide 6 Coul	d not be 28e. Place of	Injury - At home, f	arm, stre		office			28f. Location (. City or Ton	Street a	nd Numb			h Ra	
29a. Certif (Chec	fier 1□ Certify ck only 2 Medic	ying Physician: To the basial Examiner: On the basiand manner	est of my knowledg	e, death	occurred a	t the tim	e, date ar inion, dea	nd place,	and due to the	cause(	s) and ma	nner as s and due to	tated. the cause(s)		
29b. Signa	ature and title of certif			29c. License number O.C.M.E.					29d. Date signed (Month, Day, Year)  November 7, 2004						
30. Name	and address of person	on who completed cause	of death (Item 23a)	(Type,	Print)			eet,	Baltim				2.700	1	

State

31. Date filed (Month, Day, Year) NOV 1 7 2004

Registrar

			1 - For State Registrar	State of	Marylan		artment of			d Mental	Hygie	200	11.	300	10
			Decedent's Name (First, Middle, Last	st)						2. Date	of Death		77_	3. Time of I	Death
	Physici		ANN PERGE	RICHT	•					NOVE		11, 2	Year 2004	7:45	ΡМ
	/Medio		4a. Facility Name (If not institution, give				4b. City, Tow	n, or Loc	ation of D			4c. County		17013	-
	_xam.		HEBREW HOME OF GR	EATER WA	ASHINGT	'ON	ROCKV	E		MC			MONTGOMERY		
	Funeral		5. Social Security Number 6. S		. Age (In yrs.	If Under 1 Ye		Under 24 lours	Hrs. 8. Date of	of Birth	Year) 9. Birthplace (S		place (State or	r Foreign	
п	Director		301–36–4744 1□M 2¬F 81 Yrs.				MOREIS Da	lys II	lours	SEPT	12,	1923	POLA	ND	
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	eation							10d. Inside City	he i imito
	larylan show	'n												1 ∏ Yes	•
	he M	Director	MARYLAND MONTGOM  10e. Street and Number	ERY	RO	CKVILL	E 10f. Zip Cod				10-	0%	N/5 - 1 O		
	with with	늅	6121 MONTROSE ROA	D				852			lug.	Citizen of V	vnat Coul	itry !	
	ns 23	era	11. Marital Status	12. Was Deced	lent Ever in II	S 13 1			nic Origin	? (Specify Yes	or No-	14 Bac	e - Americ	can Indian,	
	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene. I death than "netural", or items 23e or 28e-f show of other than "netural", or items 23e or 28e-f show awant, its Medical Examination in the modified at	Funeral	1 ☐ Never Married 2 ☐ Married	Amed Ford	es?		f Yes, specify C	Cuban, M	lexican, P	uerto Rican, etc	)		k, White,		
036	al', o	þ	3 ♥ Widowed 4 □ Divorced	If Yes, Give Year or Dat			1 ∐ Yes 2 <b>X</b> ∑1	No S	pecify:			Specify	': W	HITE	
21215-0036	72 ho netur	Completed	15. Decedent's Ec	lucation			dent's Usual Oc kind of work do			working	161	. Kind of Bu	usiness/In	dustry	
2	ithin Ban *	npie	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use re	tired)	9 00. 0.	···o··································					
C	filed with Hygiene. other than		12			S	EAMSTRE					TAILO			
Maryland	ould be fi Mental H arkad otl atic evar	Be	17. Father's Name (First, Middle, Last)  CHAIM LIPSC	UTT7				18.	FAIG	Name (First, M		oen Sumam NKNOWN			
Ž	should by nd Menta markad umatic ev	L C	19a, Informant's Name/Relationship			10h Mailir	Address (Str	not and l		r Rural Route N				Cadal	
Ma	d 2 sho th and t7 is mu traum	1	FRAN P. KUPERMAN,		מי					R., ELL		-			
	Health Health tam 27 i	13	20a. Method of Disposition	Dittotill	20b. P	lace of Dispo	sition (Name of	,	JOL L	Date		Location -			
OLL	0 0 = - N		1 🕅 Burial 2 □ Cremation 3 🕅  1 □ Donation 5 □ Other (Specify		tate	-	natory`or other   DRIAL PA		111	/14/2004	BE	TRORD	HETC	GHTS, O	OTH
Baltimore,	permit. Pag Department Important: I any injury o		21. Signatur of Fineral Service Lijen		DIO									1110, 0	111.0
B	permit. Depart Import any inj once.		1 Jonesta	Jane	_	10	WARD SA	KGEL (VII.I	FUNE F. P.	RAL DIR	ECTI(	ON, IN LE. MI	NC. 20	852	
	*		23a Part1 Finter the disease or comp	olications that ca	used the death									Approximate Interval Betw	) yoon
	Physician <sup>*</sup>		Immediate Cause (Final disease or condition			MIC	-ARD	IDN	1401	PATHY				Onset and De	
	/Medical		resulting in death)		r as a consequ	ience of).									
	Examiner		Sequentially list conditions,	b. COI	RONA	RY 1	4RTEI	2 4	DI	SEAS	<u> </u>				
	bed isi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequ	uence of):									
	and and and	xan	that initiated events resulting in death) Last	c	r as a consequ	uence of);									
68760,	cate be executed physician and the burial-transit	aiE	l		·	,									
		edicai													
Вох	leath certific attending p	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc								23d. Dat	Date of delivery		
œ.	death e atte	Physician/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□Pregna	th 2 ☐ Fetal nt at time of de		]Ectopic pregna ] Other (specify				_	Mor	nth	Day Ye	ear
P.0	at the de by the tached	hys		9□ Unknov											
ŝ	The law requires that the death certif sie has been signed by the attending page 2 should be detached for use as	by F	Part II. Other significant conditions o	ontributing to dea R TEN ら		alting in the u	nderlying cause	given in	Part I.			\/		ne cause of de	
Records,	v requir been si should		11/12	NIEN	DIOJV					-	1 🗌 Yes	2/No	3 🗌 Prob	ably 4 Ur	nknown
ec	e law r has be	Completed									Was an autopsy	24b. V	Vere auto	psy findings av	vailable use of
		Con								1 🗆 Y	performed		leath? □ Yes	2 No	
Vital	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Lite a mittalle				0.1		Death (Check o					
of	Physi this c	မ	1 Yes 2 No			ER/Outpatien	1 3 DOA		XVursir	ng Home 5				1)	
no	ding I h. After funer	ion	27. Manner of Death 1 Natural 5 ☐ Pending		, Day Year)	28b. Time of Injury		Nork?	2 🗆 No	28d. Desc	ribe now i	njury occurr	ed		
isio	Vttandii death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be		of Injury - At ho	me farm str	eet, factory, offi		2 🗆 140	28f. Locati	on (Street	t and Numbe	ar or Rura	l Route Numb	ner .
Division	II or Attand after death   Diractor: . d in by the f	Certification:	4 Homicide determined	building	g, etc. (Specify	()	sot, ractory, one	00		City o	r Town, S	tate)	J. 01 71012	7 TOBIO MUNDO	Or,
_	spita cours neral / fillec		29a. Certifier 1 Certifying Ph												
	To the Hospital or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medicai	(Check only 2 Medical Exam		sis of examinat										
	To the vithing to the complete	Ž	29b. Signature and htte of certifier	0.0				ense nur	-11			Date signed			
	3		1 / IND	custer,	M.D.		101	80	84		11/0	VEM	BEI	R122	.004
	2		30. Name and address of person who	completed cause	of death (Item	23a) (Type,	Print)		0 0	Rock	W		2000	~ ~	
		1	DINESH PA	TEL M	D. 01	21 M	ONTRO	SE (	KY,	KOCK	JILLE	7 41	) 21	1857	-
	Sta Registr		31. Date filed (Month, Day, Year)	104 32. R	gistrar's Signa	M A	Low	61	,		,	,			

ANN PERGERICHT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38213 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** 15<u>,</u> Nov. Robert Paul Quinn, Sr. 2004 10:28AM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Civista Medical Center Plata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Feb. 5, 192 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 🕅 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months 174-22-3401 75 Director 1929 Illinois Usuel Residence of Decedent daath with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural, or items 23a or 28a-f sho the Medical Examiner must be notified at 1 □ Yes 2 No by Funeral Directo Charles Waldorf Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number Kolect F, Duing Baltimore, Maryland 21215-0020 11080 Weymouth Court #221 20603 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Dates: Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd 2 should be filed within sith and Mantal Hygiene.
27 is marked other than "refraumatic event, the Mark than" Elementary/Secondery (0-12) College (1-4or 5+) Sales Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Michael Quinn, Sr. Mary Helen Graizer Pages 1 and 2 should nent of Health and Man 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trau Patricia Quinn - Wife 11080 Weymouth Ct. #221, Waldorf, MD 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-19-04 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 22. Name and Address of Facility
Huntt Funeral Home 21. Signature of Juneral Service Licensee M01391 P. O. Box 156, Waldorf, MD 20604 23a. Part1. Efter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical INTRACEREBRAL HEMORRHAGE 72 HRS **Examiner** Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s tha burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) attending pl for use as t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 → No 3 Probably 4 □ Unknown HTPERTENSION Š 24b. Were autopsy findings available prior to completion of cause of death? certificata has been si irector, page 2 should 24a. Was an autopsy performed? Completed 30 No 1. Yos 1 ☐ Yes 2 ☐ No Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 → mpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

Division of Vital Records, P.O. Box 68760, To the Hospital or within 24 hours aftar death.

To the Funeral Director: After this

Medicai State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

D-28281

29d. Date signed (Month, Day, Yeer) 11/16/2004

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

Benjers, MD 9131 Piscataway Road Suite 600 Clinton, MD 20735 Nelson V. 31. Dete filed (Month, Day, Year)

NOV 1 6 2004

32. Re ristrar's Signeture

			1 - State Amend Item 2. Registrar	State of M 5 per me (	aryland/Dep G839 1-18-2	artment hillcate	of Hea	alth ar eath	nd Mental Hy	giene Reg. No. 2001	+ 38214		
	Physici		1. Decedent's Name (First, Middle, La. PAULA RIS	st) TOM					2. Date of De Month	Day Year	3. Time of Death  12:30p <sup>M</sup>		
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number	)	4b. City, To	wn, or Lo	cation of		4c. County of Dea			
			Calvert Memor	ial Hospi	tal				erick	Calver	rt		
	Funeral		5. Social Security Number 6. S	ex	ge (In yrs. last birthday, Yrs.	If Under 1 Months [		f Under 24 Hours	Min. (Month, Da	th 9. Bil	rthplace (State or Foreign ountry)		
	Director		579–64–7098 Usual Residence of Decedent	- 4	56 Yrs.				Oct. 1	4, 1948 Washington D.C			
	yland		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits		
	Mar a-fst	tor	MD Calvert		North E	Beach					1 ☐ Yes 2 No		
	ith the	Director	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·		10f. Zip C	ode			10g. Citizen of What C	ountry?		
	ath w		3704 3 <sup>rd</sup> Stre	Y			714			U.S.A.			
	er de Iteme	Funerai	11. Marital Status	12. Was Deceden Armed Forces	?	Was Deceder If Yes, specify	t of Hispa Cuban, I	anic Origir Mexican, f	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Am Black, Whi			
39	irs aft	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X If Yes, Give Year or Dates:		1 ☐ Yes 2 🖸	I No S	Specify:		Specify:	vito.		
ò	d within 72 hours after death with the Maryland giene. Ir then "naturel", or Itema 23a or 28a-f show Tre Medical Evant et must be notified at	ted	15. Decedent's Ed	lucation	16a. Dece	dent's Usual (	Occupatio	on.		16b. Kind of Business	lite VIndustry		
218	within 7 ene. than "n re Med	Completed	(Specify only highest gra	College (1-4or	(Give life.	kind of work DO NOT use	done durii retired)	ing most o	f working				
2	ed wi	Cou	12		Hon	emaker				Own Home	9		
and	be filed ntal Hyg sd other svent,	Be	17. Father's Name (First, Middle, Last)				18		Name (First, Middle	,			
ž	should be ind Menta i marked umatic sv	2	John Edwin Les  19a, Informant's Name/Relationship (		10h Maili	na Addrana /G	'tmat and	He_	len Larime	r er, City or Town, State,	7:- C- (-)		
Ma	·		George Riston Jr	,, ,					th Beach,		ZIP COde)		
Je,	s 1 and 2 of Health a item 27 Is other tra	ì	20a. Method of Disposition	• (nusba	20b. Place of Dispersion cometery, cre	osition (Name	of	IVOL	Date	20c. Location - City or	Town, State		
9	Page nent o nt: If		1  Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specifi		,			ns No	v. 13. 20	04 Dunkiı	rk MD		
Baltimore, Maryland 21215-0036	permit. Pages of Popartment of Himportant: If ite any injury or ot once.		21. Signature of Funeral Service Licer	isee / 1 /	7 2	2. Name and	Address o	of Facility	ee Funera	1 Home Calv	vert. P.A.		
<u>m</u>	84 = 88		Denielle/Ward	Marx	81	.25 Sou	ther	n Mai	vland Blv	d. Owings.	MD 20736		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. Do not en line.	ter the mode of	of dying, s	such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	d	106 ENIC	SH	1064	( .			Onset and Death		
	/Medical Examiner		resulting in death)		s a consequence of):	FA	ILUI	RF					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	s a consequence of):								
	cuted nd ransit	Examiner	that initiated events	a ALU	OHOL W	ITURA	UAL	_	SEIZURE	5-11			
ó,	the death certificate be executed y the attending physician and iched for use as the burial-transit.	i Ex	resulting in death) Last	Due to (or as	s a consequence of):				D .1	VED BY MEDICAL			
8760,	icate b physic s the b	edicai	•	d					COTIEN ATION APPRO	VED BY MEDIO			
9 X	eath certific attending pl	/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy			(	ERTIFICATION				
Вох	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Fetal death 3	Ectopic preg				23d. Date of de Month	livery Day Year		
P.O.	the d by the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown									
	law requires that the de as been signed by the a 2 should be detached t	by PI	Part II. Other significant conditions of	ontributing to death	but not resulting in the u	nderlying caus	se given ir	n Part I.	23e. Did t	obacco use contribute to	the cause of death?		
ıd	w require been sig should b								10	res 2 1 No 3 □ Pi	robably 4 Unknown		
Division of Vital Records,	law ra as be	Completed							24a. Was		utopsy findings available completion of cause of		
= H	sician: The law certificate has b irector, page 2 s	Con							perfo 1 ☐ Yes	rmed2 death? 2 No 1 ☐ Yes			
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:					Death (Check only o				
of	this ald	. To	27. Manner of Death	28a. Date of Inj			Injury at	4 🗌 Nursi		dence 6 Other (Spe	city)		
on	ding f th. After funer	tion	Natural 5 Pending 2 Accident investigation	(Month, Da	ay Year) Injury	м 233	Injury at Work? 1 ☐ Yes	2 □ No		iow injury occurred			
Visi	al or Attending F s after death. I Director: After d in by the funera	ifica	3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm, st	reet, factory, o	ffice		28f. Location (S	Street and Number or Ri	ural Route Number,		
Ö	tal or	Certification:	4 🔲 Homicide	building, e	tc. (Specify)				City or Tov	vn, State)			
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (	(Check only 2 Medical Exan	ysician: To the best	t of my knowledge, deat of examination and/or in	h occurred at t	he time, o	date and p	place, and due to the	cause(s) and manner as	s stated.		
	the hin 2 the hin 2 the him	Med	one)	and manner s	tated.		icense nu						
)	To cor	-	29b. Signature and title of certifier  Nay a vlaus	Medic	ي ۸ر			1mber 063		29d. Date signed (Mont	n, ∪ay, rear)		
			-							/ 1			
	5		30. Name and address of person who ICO HOSPI 31. Date filed (Month, Day, Year)	TAL R	OAD I	TARYLA	IND	121	U-SA	95000			
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	ras Signature	Acar	<b>2</b> p						
	Registr	ar	INO A T	0 2004	SCHOOL IS	AND TOP AS		_					

Jourd do me if as is perme

			1 - For State Registrar	State of Maryland		artment of H		Mental Hyg	iene g. No.201	04	38215		
	Physici	an	1. Decedent's Name (First, Middle,	Last)				2. Date of Deat Month		Year	3. Time of Death		
	/Medic		William	Thomas Row	е			Novembe		004	5:00 p.m.		
	Examin	er	4a. Facility Name (If not institution,				r Location of Deat	h	4c. County o				
			45870 Boothe	Road  S. Sex 7. Age (In yrs. Ia	et hirthday)	Dr If Under 1 Year	ayden If Under 24 Hrs	8. Date of Birth	St. I		Slace (State or Foreign		
I.	Funeral Director		216-16-7332	1 ■ M 2 □ F 81	Yrs.	Months Days	Hours Min.		Year)	Country) Maryland			
	D		Usual Residence of Decedent					TED. 13	91725	mai	yranu		
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jisal Evanii at must be instilled at		10a. State 10b. County	10c. City,	Town or Lo	cation				10	0d. Inside City Limits		
	8a-1 s	cto		fary's			Mary's C:				1 ☐ Yes 2 € No		
	with the nor 2 be no	Dire	10e. Street and Number			10f. Zip Code		11	10g. Citizen of What Country?				
	s 234	erai	47928 Watery	riew Drive 12. Was Decedent Ever in U.S	13.1		1686		United States 14. Race - American Indian,				
	fter d	Funeral Director	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?	.   10.1	Was Decedent of H f Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Black	k, White, e	etc.		
036	al', o	by	3 ₩Widowed 4 Divorced	Specify:		Specify:	Whit	te					
21215-0036	72 ho natur	Completed	15. Decedent's (Specify only highest	s Education grade completed)	16a. Deced	dent's Usual Occup	ation during most of wo	rkina	16b. Kind of Bus	iness/Ind	lustry		
21	within sene.	mpj	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	1)						
22	e filed within al Hygiene. I other than " vant, Ine Me		17. Father's Name (First, Middle, L	6 l		Artist	18 Mother's Na	me (First, Middle, M	Art				
and	outd be f Mental is larked or	o Be	John Isaac F	,				rriett B		,	_;		
Maryland	2 should be and Mental is marked (	To	19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Street		ıral Route Number,		State, Zip	Code)		
	and 2 salth a n 27 is		Nancie L. Lumpk	ins / Daughter	1673	O Piney P	oint Roa	d, Piney	Point.	Mar	land 20674		
ore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-1 show any rightry or other traumatic avant, the Medical Examinational Le inclified at ODGs.		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of natory or other place			20c. Location - C				
Ē	Page nent ant: If ury or		1  Burial 2  Cremation  '4  Donation 5  Other (Sp	ecify) St.	Micha	el's Cem.	11-2	23-2004	Ridge,	Mary	land		
Baltimore,	permit. Departr Imports any inj once.		21. Signature of Juperal Strucy L	3	22	. Name and Addres	ss of Facility Br	insfield	Funeral	L Hon	ne, P.A.		
_	70 E 8 9			field, Jr. M000						, MD	20650-0279		
				complications that caused the death. Inly one cause on each line.	Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arre	est,		Approximate Interval Between Onset and Death		
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a	CV	D				>	CARS.		
В	Examiner		,	Due to (or as a conseque	ence of):								
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	cate be executed by sician and the burial-transit	Examine	cause. Enter Underlying Cause (Clease of Light) that initiated events	с									
ó	a exectan an an an an an an an an an an an an a		resulting in death) Last	Due to (or as a conseque	ence of):								
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physiclan/Medical		d									
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Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal of	death 3□	Ectopic pregnancy Other (specify)	•		23d. Date Mont		ry Day Year		
P.O.	that the de ned by the a detached f	ıysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	5_	Other (specify)							
	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant condition	ns contributing to death but not result	ting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contrib	oute to the	e cause of death?		
rds	w requires that s been signed E should be deta	ed b	· SE/ZUPES					1 □ Ye	s 2 10 3	3 🗌 Proba	abły 4 □Unknown		
900	e law re has bee	Completed	· ARTHRITI-	5				24a. Was ar	24b. W	ere autop	osy findings available		
Ě	The ate h page	Com	· ATHAL F	SPILLATION				perform	ned2_ de	ath?	2 No		
/ita	yalcian: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?					ath (Check only one			Daughter's		
of Vital Records,	d is	70	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatier 28b. Time of		4 🗀 Nul Sing i			r (Specify,	Residence		
uc	ding I	tion	27. Manner of Death  1 □ Natural 5 □ Pending 2 □ Accident investig	(Month, Day Year)	Injury	Worl	yat k? Yes 2⊡No	28d. Describe ho	w injury occurre	u .			
Division	for Attanding after death. Diractor: After In by the fune	fical	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of Injury - At hon	ne, farm, str			28f. Location (Str		r or Rural	Route Number,		
$\overline{0}$	ator A s after I Dira	Certification;	4 Homicide	building, etc. (Specify)				City or Town	, State)				
	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral			Physician: To the best of my know xaminer: On the basis of examination									
	To tha H within 24 To tha Fi complete	ledical	one)	and manner stated.	on and or in			,					
ı.	To tha within 2 To tha complet	Σ	29b. Signature and title of certifier	AA	7	29c. Licens			d. Date signed				
į			140m	,0		036	5046		1-65.00	r			
,	5 00		30. Name and address of person v	tho completed cause of death (Item :	23a) (Type,	Print)	OTCH R	D HOWY	WOOD	MD	20636		
	Sta	te	31. Date filed (Month, Day, Year)	32. Régistrar's Signatu	ire,	barke	, ,	/ /	-				
	Registi		NOV 2	4 2004 Marcar	J. A	serie!							

State of Maryland / Department of Health and Mental Hygiene 0 0 L 1 - State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** November 12, 2004 12:01 A M CATHERINE ANN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/02/1937 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F Director 219-32-8732 Maryland Usual Residence of Decedent the Maryland 10h Counts 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f ahow ust be notified at 1 Xes 2 No Director Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 3802 Donnell Drive 20747 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian other traumatic evant, the Musical Examinents Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3 years Division Manager Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Catherine Robertson Elmer Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum 9006. Samuel S. Ross, Jr. - Son 3802 Donnell Drive; Forestville, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/18/04 \* 4 □ Donation 5 □ Other (Specify) Arbutus Mem. Park Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services Lendan truenar P.O. Box 416; Suitland, Maryland 20752 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis

Due to (ras a consequence of) Priysician disease or condition resulting in death) /Medical **Examiner** holangitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in that and available of the conditions of Due to (or as a conviguence of) Examiner certificate be executed burial-transit Pancreatic cancer that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2**X** No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Impatient 2 ER/Outpatient 3 DOA 2 1 Tes this 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 atural 5 Pending death. investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated. To the within 2 29b. Signature and title of Periods 29c. License number 29d. Date signed (Month, Day, Year) ou man D0053813 Mark R. Dumais 7503 Surratts Road. Clinton, MD (3 1ark R. Dumais 2. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 7 2004 Registrar

**Physician** /Medical Examiner

**Funeral** Director

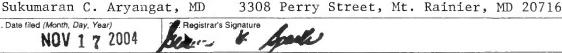
For	State of Maryland / Department of Health and	Mental
State Registrar	Certificate of Death	
Decedent's Name (First, Middle, Last)		2. Date Mon

1 - For State Registrar	State of Marylar	nd / Depa <i>Cer</i>	irtment of F tificate of	lealth and M <i>Death</i>		iene2 () () (4	38217
Decedent's Name (First, Middle, Last	<i>it)</i>				2. Date of Deat	h	3. Time of Death
Robert Richard R					Month Novembe	r 14, 200	
4a. Facility Name (If not institution, give			4b. City. Town, o	Location of Death		4c. County of Dee	
Prince George's		er	Cheve			Prince	
5. Social Security Number 6. S	<u> </u>		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, 7 / 1 1 / 19	o Ric	rthplace (State or Foreign
230 40 7140	7	113.			//11/19	34 Wes	t Virginia
Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
							13∑Yes 2 No
Maryland Prince	George's 1	Mount R	10f. Zip Code		11	Og. Citizen of What C	ountry?
Maryland Prince  10e. Street and Number  4212 34th Stree  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest graen)  Elementary/Secondary (0-12)  6  17. Father's Name (First, Middle, Last)	t			12-1736		USA	ountry.
4212 34011 30166		10 10 1			2014 Vac as \$10	14. Race - Am	origan Indian
11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. V	Yas Decedent of H Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, Whi	
1 Never Married 2 Married 3 Widowed 4 ☼Divorced	1 ☐ Yes 2 🚰 No If Yes, Give Year or Dates:	1	□Yes 2🌣 No	Specify:		Specify:	White
15 Decedent's Es		16a Docor	lent's Usuai Occup	ation		16b. Kind of Business	:/Industry
15. Decedent's Ed (Specify only highest gra	de completed)	(Give	kind of work done	ation during most of worki d)	ing	. Job., Italia of Business	a made in y
Elementary/Secondary (0-12)	College (1-4or 5+)	,,,,,	Painter	7		Construct	ion
17. Father's Name (First, Middle, Last)		1	TUTILET	18. Mother's Name	First. Middle. A		LUII
William Herber	t Rogers				hy Ruth		
		405 14:33				City or Town, State,	To Codel
19a. Informant's Name/Relationship (7) Pamela Sue Lafton	**					nicsville	
20a. Method of Disposition  1 ⊠Burial 2 □ Cremation 3 □  1 □ Donation 5 □ Other (Specify	Removal from State Cha	cemetery, cren	sition <i>(Name of</i> natory or other place emorial (			20c. Location - City of eonardtown	Town, State
21. Signature of Funeral Service Vicen	800		Name and Addre	O Can		neral Home	•
23a. Part1. Enter the disease, or com-	plications that caused the dea						Approximate Interval Between
shock, or heart failure. List only Immediate Cause (Final	Congestive 1	Hoart E	ailura				Onset and Death 2 weeks
disease or condition resulting in death)	Due to (or as a conse		allule				1
	Ischemic Ca:		nathy				More than 1 year
Sequentially list conditions,	b. Due to (or as a conse		pachy				More than
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Diabetes	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					1 year
that initiated events resulting in death) Last	c Due to (or as a conse	guence of):					
	Acute Atria		11ation				3 weeks
	d						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of Acute Renal Fa	23c. If yes, outcome of pregn	anav.				2015.11	
23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 ☐ Fet	al death 3	Ectopic pregnancy	,		23d. Date of de Month	Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5∟	Other (specify)				
	antification to double but not so	authing in the un	darking stuck an	en in Cont I	22a Did tob	agen use contribute t	to the cause of death?
Part II. Other significant conditions of Acute Renal Fa	-	summy in the Ur	idenying cause giv	on ai Fait i.			robably 4 Unknown
Acute Cholecys	titic				240 146	O.4h Wass -	utoney findings available
Acute Cholecys	LILIS				24a. Was an autops perform	y prior to	utopsy findings available completion of cause of S 2 No
25. Was case referred to medical examiner?				26. Place of Death	(Check only on	9)	
examiner/ 1 ☐ Yes 2 ♣ No	Hospital: 1 ☐ Inpatient 2 □	] ER/Outpatien	t 3 DOA	er: 4 🗌 Nursing Ho	me 5 Reside	nce 6 Other (Spe	ecify)
27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe ho	w injury occurred	
1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	1			Yes 2 □No			
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, stre	eet, factory, office		28f. Location (Sti City or Town	reet and Number or R , State)	lural Route Number,
(Check only 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin						
one)	and manner stated.		29c. Licens	e number		d. Date signed (Mon	th Day Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 1 7 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

29c. License number D 15558 29d. Date signed (Month, Day, Year)

11-15-2004

				State of Maryland				-		egible.	
		•	For State Registrar	oraco or many tarre		rtificate of I		•	Rag. No.	004	38218
			Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Vans	3. Time of Death
	Physici /Medic		EDGAR FERRAND RUM	MEL				Novemb	er 13	3, 2004	4:30 a M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of De	ath	4c. C	ounty of Death	
			7812 Adelphi Cour			Ade1ph				ince Ge	
	Funeral		5. Social Security Number 6. Sex	14 cD 5	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, Da	th ly, Year)	9. Birth Cou	place (State or Foreign
Н	Director	}	413-32-0888 Usual Residence of Decedent	75	113.			June 29	, 192	9 Nort	h Carolina
	land ow		10a. State 10b. County	10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Many a-f sh fied	to	Maryland Prince G	eorge's		Ade	1phi				1 ☐ Yes 2X No
	th the	Director	10e. Street and Number	72		10f. Zip Code			10g. Citize	on of What Cou	ntry?
	23a ust b	la	7812 Adelphi Cour	t			20783			3.A.	
	tems	Funeral	Tr. Maritai Otatas	2. Was Decedent Ever in U.S Amed Forces?	3. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	)- 14	<ol> <li>Race - Ameri Black, White,</li> </ol>	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 📉 Yes 2 🗌 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖔 No	Specify:		5	Specify: Wh:	ite
Maryland 21215-0036	d within 72 hours after death with the Maryland Jiene. Ir then "naturel", or Items 23a or 28e-f show The Medical Examiner must be notified at		15. Decedent's Educ	eation	16a. Dece	dent's Usual Occup	ation		16b. Kind	of Business/Ir	
215	hin 72	piet	(Specify only highest grade Elementary/Secondary (0-12)	Coilege (1-4or 5+)	(Give life.	kind of work done of DO NOT use retired	during most of v d)	vorking			
21	75	Completed		5+	Atto	rney			Law	J	
nd	be filed tal Hygid of other event, II	Be (	17. Father's Name (First, Middle, Last)					lame (First, Middle			
yla	should be and Mental marked o	은	Robert French Rumm					Jeanette			
Mar	2 she rand raum		19a. Informant's Name/Relationship (Typ			ng Address (Street					
	s 1 and 2 should be filed if Health and Mental Hyg item 27 is marked othe other traumatic event,		Kathleen Franklin 20a. Method of Disposition			COLUMD 1a	Pike,	Apt. 407,		ngton, ation - City or T	VA 22204 own, State
Baltimore,	ages nt of I :: If it		1 ☐ Burial 2 X Cremation 3 ☐ Re	emoval from State	metery, crei	matory or other place		/16/2004			Virginia
뜶	artmer artmer artant injury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		-	LLan Crena  Name and Addre	- ,				
Ba	permit. Pages 1 a Department of Hei Important: If item any injury or othe		11/4/	May		739 Balt					
			23a. Part1. Enter the disease, or complic	cations that cars the death.							Approximate Interval Between
	Pnysician		shock or heart failure. List only on Immediate Cause (Final	- A							Onset and Death
	/Medical		disease if condition resulting in death)	. Pancreatic C  Due to (or as a consequ	-					-	3 Months
	Examiner		Sequentially list conditions b								
	ъ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cluce (Disaste of high) that initiated events	Due to (or as a consequ	ence of):						
	ecuter ind trans	Examiner	that initiated events cresulting in death) Last								
760,	te be executed ysician and le burial-transit		Todaking in doday sade	Due to (or as a consequ	ence or):						
687	<u> </u>	dical	d								
9 ×	The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 25	3c. If yes, outcome of pregnar	ncy				23	d. Date of deliv	erv
Вох	leath atter	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)	′			Month	Day Year
0	at the de by the a tached	hysi	9 Unknown	9□ Unknown							
۳,	es that igned b	by P	Part II. Other significant conditions con	tributing to death but not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
ğ	w require been sig should b							_ 1 🗆	Yes 2 🛚	No 3□Pro	bably 4 □Unknown
Records,	e law re has bee	piet						24a. Was		24b. Were aut	opsy findings available ompletion of cause of
Ä		Completed						perf 1 ☐ Yes	ormed?	death?	2 □ No
Vital	iclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?					Death (Check only			
of \	Physician: this certific ral director,	은	1 ☐ Yes 2X No	ospital: 1 ☐ Inpatient 2 ☐ E				g Home 5 N Res			fy)
	ing After une	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	k?	28d. Describe	now injury	occurred	
Sic	Attending r death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	mo farm et		Yes 2 □ No	28f Location	Street and	Number or Rur	al Route Number,
Division		Certification:	4  Homicide determined	building, etc. (Specify)	)	eet, ractory, onice			wn, State)	74077207 07 7107	ar rioute reamber,
	e Hospital or 24 hours afte e Funeral Dir etely filled in			ician: To the best of my know							
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical		ner: On the basis of examinati and manner stated.							
	To the within 2 To the complet	Ř	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
,			Andre C. Ke	CM. and		D005	8645		Novem	ber 15	2004
)	(10)		30. Name and address of person who co	mpleted cause of death (Item	23а) (Туре,	Print)					
			Andrea C. Karp, M			Lcut Aven	ue, Ken	sington,	MD = 2	20895-21	139
	Sta Regist		NOV 1 7 2004	3 Registrar's Signat	Lo	we					
			MAN T I man.	1							

			1- State of Maryland / Dep	ertment of Health and ertificate of Death	Mental Hygie	ne2004	38219
		'Str	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		ELIZABETH C. RAYBON		November	Day Year 13, 2004	2:20 p M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Deat	
*.			Larkin Chase	Bowie		Prince Ge	eorge's
	. Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year   If Under 24 Hr Months Days Hours Min	(Month Day Ye	(Co	nplace (State or Foreign untry)
	Director		577-34-1564 1□M 2⊠F 75 Yrs.		March 30,	1929 Pen	nsylvania
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	fanyl faho	ō	Maryland Prince George's Upper M	far1boro			1 ☐ Yes 2 📉 No
	28a-	Director	10e. Street and Number	10f. Zip Code	10g	Citizen of What Co	untry?
	with Se or		7108 Sybaris Dríve	20772	1 2		,-
	ns 2%	Funeral		Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	U.S.A.	ncan Indian,
20	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23a or 28a-f ahow aumatic event, the Marical Examiner must be mailtied at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No		rto Rican, etc.)	Black, White	e, etc.
<u>8</u>	rel', c	l by	3    Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: W	hite
2-0	72 honatu	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation  e kind of work done during most of we	orkina 16t	. Kind of Business/l	ndustry
2	ithin Jen.	npl	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
2	led w lygier her ti	S		phone Operator		Communicat	ion
and	be d d	Be	17. Father's Name (First, Middle, Last)		ame (First, Middle, Mai	den Sumame)	
$\frac{8}{5}$	should nd Men marke umatic	은	Patrick Flannery		eesnitzer		
Maryland 21215-0036	12 sh h and 7 Is n traun			ling Address (Street and Number or F			
ď	is 1 and 2 should by Health and Men item 27 is marke other traumatic		James Edward Thompson - Son 710  20a. Method of Disposition 20b. Place of Disp	8 Sybaris Drive,		.Doro, Mar .Location - City or	
altimore,	Pages nent of I int: If its iry or o		1 ⊠ Burial 2 ⊠ Cremation 3 □ Removal from State cemetery, cre	ematory or other place)		,	
Ξ	artme ortani injury			Heaven Cemetery 11/ 22. Name and Address of Facility Ga			
Ba	permit. Pages Department of Important: If it any injury or o			739 Baltimore Ave			
			23a. Part 1. Anier the disease, or complications that — sed the death. Do not er shock, or heart failure. List only one cause or a ch line.	nter the mode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition Multi Organ Failu				Onset and Death
	/Medical		resulting in death)  a. ———————————————————————————————————				
п	Examiner		Sequentially list conditions.  b. Metastatic Cancer				
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	and and I-tran	Examin	Cause (Disease or injury that initiated events c				
8760,	cate be executed physician and the burial-transit	alE	233.5 (0. 43.2 33.154,23.133.5),				
587	E P	edical	d				
×	death certifi e attending p id for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	verv
Вох	death a atter	iclaı	in the past 12 months?  1 Ves 2 M No.  4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
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ď.	uires tha signed I	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobace	co use contribute to	the cause of death?
ğ	aquire an siç ould b		Chronic Obstructive Pulmonary Diseas	e	1 X Yes	2 □ No 3 □ Pro	bably 4 Unknown
Records,	The law requires that the tee bas been signed by the base been signed by the bage 2 should be detache	Completed			24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
×	: The law cate has page 2 ;	mo			autopsy performed	? death?	2□ No
Vita	sicien: Th certificate rector, pag	BeC	25. Was case referred to medical		eath (Check only one)		
	die S	To	examiner? 1 ☐ Yes 2 🏋 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ont 3□ DOA Other: 4X Nursing	Home 5 Residence	6 ☐ Other (Spec	ify)
Division of	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1njury		28d. Describe how in	njury occurred	
20	Attendideath. ctor: A y the fu	catl	2 Accident investigation	M 1 Yes 2 No			
Ž	l or Attenc after death Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rui tate)	ral Route Number,
	lospitel of hours at unerel D		X.		1		
	24 h	edical	29a. Certifier  (Check only one)  2 Medical Examiner: On the basis of examination and/or is and manner stated.	nvestigation, in my opinion, death occ	e, and due to the cause curred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of pertifier	29c. License number	29d.	Date signed (Month	, Day, Year)
	- 3 = 0		· Xun.	D4165	50 1	1/15/8	Y
)	(5)		30. Name an ordress of person who completed cause of death (Item 23a) (Type	, Print)	,		
			Arnulfo Bonavente, M.D. 6409 S. Cr	ain Hwy, Upper Ma	rlboro, Ma	ryland 20	772
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature				
	Registr	ar	NOV 1 7 2004	all of			

State of Maryland / Department of Health and Mental Hygier 38220 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EARL WILLIAM REED NOV -Day 15 2004 9:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | AUG 18 1923 6. Sex / 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number 214-28-9139 Birthplace (State or Foreign Country) Funeral 81 Director MD Usual Residence of Decedent with the Maryland 10h County 10c. City, Town or Location 10a State 10d. Inside City Limits item 27 is marked other then "naturel", or items 23e or 28a-f show other treumatic event, the Medical Examiner must be notified at MD MONTGOMERY BOYDS 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20841 USA 20015 BUCKLODGE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 □ No 1944 If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should ba filed within 72 hours after on and Mental Hygiene. Is marked other then "naturel, or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FOREMAN CONSTRUCTION 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERMAN REED MARY ARNOLD 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2. Department of Health au Importent: If item 27 Is eny injury or other treu once. WANDA SMITH / DAUGHTER 2540 OAKRIDGE DR., JONESVILLE, MI 49250 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GERMANTOWN BAPTIST 11/19/04 GERMANTOWN, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MCTASTATIC COLON CANCER Pnysician 6 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CDCMA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 M No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No Hospitel or Attending Physiclen: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After t 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deatl Funerel Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29c. License number 29b. Signature and title of cer MD 44580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockwille 9711 center Medical Mark GLO GIR 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			1 - For State Registrar	State of I	Maryland / I	Depa <i>Cen</i>	rtment of F	lealth and N Death	Mental Hy	gienez Reg. No.	004	38221
			Decedent's Name (First, Middle	, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medic		Edward	Shelling	Ru	dol	ph		Novemb	Day Der 12	Year 2004	2:15 p M
	Examin		4a. Facility Name (If not institution		er)			r Location of Death			unty of Death	F
			Calvert Count  5. Social Security Number		Center Age (In yrs. last bi	inth do . 1		Frederick			alvert	
	Funeral Director		579–14–0296	15 M 2□F		Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	y, Year)	Coun	**
			Usual Residence of Decedent		84			<u> </u>	Dec. 1	1910	y ⊥wasn	ington,DC
	nylan show	_	10a. State 10b. County		10c. City, Tow	vn or Loc	ation				1	0d. Inside City Limits
	Ba-f s	Director	MD Calv	ert	Chesa	apeal	ke Beach					1 ☐XYes 2 ☐ No
	with t		10e. Street and Number 3806 13th St	reet			10f. Zip Code	710			of What Coun	try?
	ns 23	Funerai	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. W	as Decedent of H	732 lispanic Origin? (Sp	pecify Yes or No	,	J.S.A. Race - Americ	an Indian,
20	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or items 23a or 28a-f show svent, the Medical Examinar must be notified at	by Fun	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	ILAVA Circa		lf lf	Yes, specify Cuba □ Yes 2∑ No	an, Mexican, Puerto Specify:	Rican, etc.)		Black, White, ecify: whi	
2-0020	2 hou	ted	15. Decedent	's Education		. Decede	ent's Usual Occup	ation	line	16b. Kind	of Business/Inc	
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and	d be findal Hed of	Be	17. Father's Name (First, Middle, I Alfred F. Ru	dolph				18. Mother's Nam				
	S should be filed within and Mental Hygiene. Is marked other than aumatic svent, ILE M.	٦	19a. Informant's Name/Relationsh		198	o. Mailine	Address (Street	Edith and Number or Rus	· · ·	obtair er. City or To		Code)
Z Z	nd 2 salth ar		Antoinette M. O		1					-	ries.	0000)
ē,	s 1 al of Hea itam othe		20a. Method of Disposition		20b. Place of	of Dispos	ition (Name of atory or other place		Date VII	2063 20c. Locati	ion - City or To	wn, State
Ē	Page nent c ant: If		1 □Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp	3 ∐Removal from Sta secify	10	•		ery Nov.1	6,2004	Brent	wood, 1	MD
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			23a. Part1. Enter the disease, or shock, or he at falure. List	complications that causonly one cause on each	h line.		r the mode of dyin	ig, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence	of):	Renal	faile	121			
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0	death certif e attending od for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth	n 2 ☐ Fetal death t at time of death		Ectopic pregnancy Other (specify)	,		230.	Date of delive Month	ry Day Year
į	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow	n							-
ν Γ	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant condition	ns contributing to deat	h but not resulting i	in the un	derlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to th	e cause of death?
cords,	equire en sig								1 🗆 '	res 2□N	o 3 🗆 Proba	ably 4\DUnknown
ב	o	ompieted							24a. Was autor perfo 1 Yes	rmed?	4b. Were autor prior to con death? 1 ☐ Yes	psy findings available inpletion of cause of
N I G	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of Deal				
5	Physician: r this certificatal director,	္ရ	1 ☐ Yes % ☐ No	Hospital: 1 Inpa				1 Nursing Ho	ome 5 Resid			)
SION	ath. r: After e funera	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investig		Day Year)	Time of Injury	28c. Injun Worl	y at k? Yes 2 □ No	28d. Describe I	now injury oc	ccurred	
2	al or Atte s after de if Diracto id in by th	Certification;	3 Suicide 6 Could n 4 Homicide determi	ot be ned 28e. Place of building,	Injury - At home, fa etc. (Specify)	arm, stre	et, factory, office		28f. Location (S City or Tox		umber or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical (	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physician: To the be Examiner: On the basis and manner	s of examination ar	e, death	occurred at the tine	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and pla	i manner as sta ce, and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	shall			29c. Licenso	e number 5029	0		gned (Month, D	
<u>I</u>	1+1		30. Name and address of person of Dhire eu	who completed cause of		(Type, P	rint)	Poinc	i F	red	MD	20678
V	Sta Registr	-	31. Date filed (Month. Day. Year)	1 5 2004 <b>3</b> 2. Regi	ist 's Signature							
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			For State Registrar		State o	f Marylar	•	oartment e ertificate			nd N		giene Reg. No.	04	38222
	Dhusial	le l	1. Decedent's Name (i	First, Middle, L	ast)							2. Date of De Month	ath Day	Yeer	3. Time of Death
	Physicia /Medic				Rebecc		th					NOVEME	ER 26	2004	5:40P M
	Examin	er	4a. Facility Name (If no	ot institution, g	ive street and nu	mber)		4b. City, To	wn, or	Location of	Death			ty of Death	
			St. Mary's 5. Social Security Num		l Sex	7. Age (In yrs.	last birthda	Leona  V) If Under 1		own If Under 2	4 Hrs.	8. Date of Bir		t Mary 9. Birth	Solace (State or Foreign
× .	Funeral Director		220-34-6820		1□M 2∏F		87 Yrs.	Months [	Days	Hours	Min.	8. Date of Bir (Month, Da April 23		Coul Mary]	ntry)
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	arylar	_	10a. State 1	l0b. County		10c. Ci	ty, Town or	Location							10d. Inside City Limits 1 ☐ Yes 2 XNo
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	with the or 2		10e. Street and Numb					10f. Zip C					10g. Citizen of		ntry?
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(0	ritten ritten	표	1 Never Married	1 2 Married	Armed Fo	rces? 2 🔯 No		3. Was Deceder If Yes, specify			Puerto	Rican, etc.)	1	ack, White,	
036	al', o	by	3 ₹ Widowed 4	Divorced	If Yes, Gr Year or D	ve lates:		1 □ Yes 2 🛭	No No	Specify:			Spec	ify: Blac	k
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anc	d be i	o Be	Frank Dyse									ell Whale		-,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or tiems 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	P P	19a. Informant's Nam		(Type, Print)		19b. Ma	iling Address (S	Street a					n, State, Zip	Code)
Š	nd 2 alth a 27 ts		Clarence Sm:	ith / Son	n		P.O.	Box 257,	Ca1	laway,	Mar	yland 206	20		
ē	s 1 a of Hei item		20a. Method of Dispos			20b.	Place of Dis	position (Name rematory or othe United	of er place	p)	Dece	Date mber	20c. Location	- City or To	own, State
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a ti	permit. Departn Importe any inju		21. Signature of Fune	eral Service Lic	e) see			22. Name and	Addres	s of Facility	· Fun	oral Homo	рΛ		
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SMITH SMITH	death e atter d for u	by Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1  Yes 2  1	onths?	1 ☐ Live t	tcome of pregn birth 2 Fet nant at time of own	al death	3 □Ectopic preg 5 □ Other (spec						ate of deliver	ery Day Year
S. P.	ires that the signed by a bedetac	by P	Part II. Other significa	ant conditions	contributing to d	eath but not re	sulting in the	underlying cau	ise give	n in Part I.			. /		he cause of death?
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	Attending Physician: r death. sctor: After this certifica by the funeral director.		27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigat	ion	of Injury oth, Day Year)	28b. Time Injury	of 28d y M	: Injury Work 1 🗆 Y	at ? ′es 2 □ N		28d. Describe	now injury occu	irred	
Division	of te	Certification:	3  Suicide 4  Homicide	6 Could not determine	200. Flace	of Injury - At h ing, etc. (Spec	nome, farm, ify)	street, factory, o	office			28f. Location ( City or To		ber or Rura	al Route Number,
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1	100		30. Name and address DANIEL AL	EXANDE	R ST. M	ARY"S H	OSPITA	AL PO B	X 52	27 LE	ONAR				
	Sta Regista		31. Date filed (Month)	Pan Year) 21	004	Registrar's Sign	ature	sets!							

				1 - For State Registrar		ryland / Dep		of Hea	Ith and M	ental Hygid	_	04	38223
_		Physici /Medic		1. Decedent's Name (First, Middle, Last)  RUTH M. SEGAR						2. Date of Death Month No VEMBE!	2 <sup>Day</sup>	Year 4	3. Time of Death  1635 M
		Examir		4a. Facility Name (If not institution, give					ation of Death			y of Death	
				M EMORIAL HOSPI  5. Social Security Number  6. Security Number		(In yrs. last birthday)		S70/V Year Ift	Jnder 24 Hrs.	8. Date of Birth		9. Birtho	
		Funeral Director			714 01710	82 Yrs.			ours Min.	8. Date of Birth (Month, Day, AUG 29 1	922	DEL	place (State or Foreign htry) AWARE
		yland how		10a. State 10b. County		10c. City, Town or Le	ocation					1	0d. Inside City Limits
		8a-fs	Director	MD TALBOT		EASTO					000	1111	XXYes 2 No
		death with the Maryland ms 23a or 28a-f show r must be redified at	i Dir	10e. Street and Number 211 SPRING DRIVE			10f. Zip (	2160	1	10	g. Citizen of US		ntry ?
		death	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decede	nt of Hispar	nic Origin? (Sp	ecify Yes or No- Rican, etc.)		ce - Americ	
<b>±</b>	036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other treumatic event, the Medical Examinat must be rediffed at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	lo	1 ☐ Yes 2		ecify:	, , , , , , , , , , , , , , , , , , , ,		fy: WHI'	
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AK	and	I be fill ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last)				18.	Mother's Nam ANNA	e (First, Middle, Ma	aiden Sumai	me)	
EGAR,	IZ N	should nd Mei mark imatic	2	SPENCER MOORE  19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mail	ing Address (	Street and I		al Route Number,	City or Town	, State, Zip	Code)
8		and 2 saith at n 27 is		ANNE S. HARVEY/DA	UGHTER	211	SPRIN	G DRI	VE, EAS	STON, MD	21601		
	altimore,	ges 1 a t of He if iten or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of Disponentery, cre	osition (Name matory or oth	e of ner place)		Date 20	c. Location	- City or To	own, State
	Ħ E	it. Pag intment intent: injury		'4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		DENTON C	EMETER			5-2004	DENTO:	N, MA	RYLAND
	Ba	permi Depar Impo any ir			MERCE	FF	LLOWS,	HELF	ENBEIN	& NEWNAM EASTON, M	FUNE	RAL HO	OME PA
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	O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the state of the st	2 Fetal death 3	⊒Ectopic pre □ Other (spe					ate of delive onth	ory Day Year
	, P.O.	s that the ned by a detac	by Ph	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the t	underlying ca	use given in	Part I.	23e. Did toba	cco use cor	tribute to th	ne cause of death?
	rds	w requires been sign should be						<del></del>		1 ☐ Yes	2 □ No	3 🗆 Prob	ably 4 DUnknown
	ecc	law re	Completed							24a. Was an autopsy	1	prior to cor	psy findings available mpletion of cause of
	al H	sician: The law certificate has b lirector, page 2 s								performe 1 ☐ Yes 2	ZNo	death?	210 No
	Zit.	siciar s certif	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatie	nt 2□ER/Outpatie	int 3□ DÖ/	Othor		th (Check only one) ome 5 🗆 Residen		her (Specif	v)
	n of	ng Phy ter this neral c	<b> -</b>	27. Manper of Death	28a. Date of Injur (Month, Day			c. Injury at Work?		28d. Describe how			,,
	Division of Vital Records,	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification:	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ury - At home, farm, si	М	1 🗌 Yes	2 🗆 No	28f. Location (Stre City or Town,		ber or Rura	al Route Number,
	Ō	spitel or nours aft, nerel Dir		29a. Certifier 12 Certifying Phy	sician: To the best of	of my knowledge, dea				and due to the cau	se(s) and m		
		the Ho in 24 ł he Fu pletely	edical	one)	iner: On the basis of and manner sta	examination and/or inted.							
4		With To 1	Σ	29b. Signature and title of certifier	tun" I.	Λ		License nui			d. Date signe	,	
				30. Name and Spress of person who co				000	1948;		11/10/	2009	
				JOHN BOTSIS M.D.				ron, M	ID 2160	1			
	• •	St Regist	ate .	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature							

Physician Action Flat Staley  Also Flischeth				For State Registrar	State of Ma	aryland		artment <i>tificate</i>			and M		iene g. No. 0	14	38224
## Course of Colors    Secular Security Humber   Color Proceded   Color Pr					Last)							2. Date of Death	n		3. Time of Death
## Course of Colors    Secular Security Humber   Color Proceded   Color Pr				Alice	Elizabeth		Stale	e <b>y</b>				Novembe:	r 22, 2	2004	7:15pm <sup>M</sup>
Citizens Nursing Home   Frederick   Frederick   Frederick   Season Season Processor   Colors   Color				4a. Facility Name (If not institution, g	give street and number)			-	own, or	Location of	of Death			of Death	
The part of the pa				Citizens Nursin	ng Home				Free	deric	k		F	redei	rick
Districtor   Control   Freederick   Total County		Funeral										8. Date of Birth (Month, Day,	Year)	9. Birthp Cour	place (State or Foreign htry)
The control of the		Director			IUM ZWIF	84	Yrs.					Jun 10,	1920	Mar	yland
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Comparison   Com	9	after or Ite		1 Never Married 2 Marrie	d 1 ☐ Yes 2 👿							moun, oto.,			
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198. Making Address (Street and Number or Rural Foulte Number, City or Town, State Zip Code)  Sylvia Springer/Niece  20a. Method of Dispation  198. Making Address (Street and Number or Rural Foulte Number, City or Town, State Zip Code)  Sylvia Springer/Niece  20a. Method of Dispation  198. Brail	5	"neti	lete	15. Decedent's (Specify only highest	Education grade completed)		(Give	kind of worl	k done d	during mos	t of worki		16b. Kind of Bi	usiness/In	dustry
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Privision (Modical Examiner  Privision (Modical Examiner)  Privisi	Σ,	T E N Z			/Niece	-				ad, F					
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Privision (Modical Examiner  Privision (Modical Examiner)  Privisi	Ë	Pag tment tant: jury		` 4 □ Donation 5 □ Other (Spe	cify)	Clu						Nov 21,	2004 Fi	reder	ick, MD
Approximate the foliable of considerations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inclined all properties of considerations and course (Final inclined all properties). The course inclined all properties of the course (Final inclined all properties). The course inclined all properties of the course (Final inclined all properties). The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties and properties. The course inclined all properties are such inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties and properties are such inclined all properties. The course inclined all properties are such inclined all properties are such inclined all properties are such inclined all properties. The course inclined all properties are such inclined all properties are such inclined all properties are such inclined all properties are such inclined all properties are such inclined all properties are such inclined all properties are such inclined all	Bal	permit Depar Impor any ir		21, Signature / Funeral Service U	W	MOO 706						P.A. Fu	neral H	lome	nd 21701
Physician (Indeficial Examiner  The proposed and course (Final deads)  The proposed and course (				23a. Part Enter the disease, or c	omplications that cause	d the death.								пута	Approximate
Due to (or as a consequence of):		Physician		Immediate Cause (Final			cor								Onset and Death
Sequentially list conditions.  Sequentially list conditions.		/Medical													I WEEK
The second of th	Н	Examine	<u></u>	Sequentially list conditions,	b. — Dua to for or	a consecutive	mea riffe								
Part   Part		uted I Insit	mine	cause. Enter Underlying Cause (Disease or injury											
State   Stat	oʻ	an and rial-tra		resulting in death) Last		a conseque	ence of):								
Part   Part	876	hysici the bu	lical	•	d										
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Part   Part	Bo	attenc for us	ian	in the past 12 months?	1 Live birth	2 Fetel c	death 3[						1		
Part   Part		y the check	ıysic			a timo or doc	2	2 Ottion (Spe	JOIIY/						
Part   Part	<u>α</u>	that ned by deta		Part II. Other significant condition	s contributing to death t	out not result	ting in the u	nderlying ca	ause give	en in Part I	l.	23e. Did tob	acco use cont	ribute to t	he cause of death?
Part   Part	rds	quire on sig uld be		Congestive Hea	<u>art Failure</u>							1 🗌 Ye	s 2 🕅 No	3 🗌 Prot	oably 4 □Unknown
Part   Part	000	aw re	plet	Coronary Arte	ry Disease								n 24b.	Were auto	ppsy findings available
26. Place of Death (Check only one)  27. Manner of Death  1 Natural  1 Natural  28. Place of Death (Check only one)  290. Death (Check only one)  290. Death (Check only one)  290. Death (Check onl	R	The ate h	E O									perform	ned?	death?	
Work?  Work of the part of Describe to the cause of determined to the cause	ita	ilen: artifica ctor, p	e e							26. Place	of Death				
State   Stat	<u>&gt;</u>	hysic his ce	.0		1 □ Inpati			_	A	477 191	_				(y)
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and delete and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mary P. Howell, M.D., 65-C Thomas Johnson Drive, Frederick, Maryland 21702-4371  31. Date filled (Month, Day, Year)  32. Registrar's Signature	n o	ing P	on:	1 Natural 5 ☐ Pending	(Month, Da							28d. Describe ho	w injury occur	red	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and delete and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mary P. Howell, M.D., 65-C Thomas Johnson Drive, Frederick, Maryland 21702-4371  31. Date filled (Month, Day, Year)  32. Registrar's Signature	Sic	ttend death stor: /	icat	3 Suicide 6 Could no	ot be 290 Place of In	iuny - At hon	ne farm st			165 2	-	28f. Location (St	reet and Numb	er or Run	al Route Number.
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and delete and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mary P. Howell, M.D., 65-C Thomas Johnson Drive, Frederick, Maryland 21702-4371  31. Date filled (Month, Day, Year)  32. Registrar's Signature	Div	i 5 te 6	ertif					oot, ractory	, ornos						
D46075 November 23, 2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mary P. Howell, M.D., 65-C Thomas Johnson Drive, Frederick, Maryland 21702-4371  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	_	spite hours nerel / fillec		29a. Certifier 1 🔀 Certifying	Physician: To the best	of my know	rledge, deat	h occurred a	at the tin	ne, date ar	nd place, a	and due to the ca	luse(s) and ma	anner as s	tated.
D46075 November 23, 2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mary P. Howell, M.D., 65-C Thomas Johnson Drive, Frederick, Maryland 21702-4371  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		the Hc in 24 I the Fu pletely	edic	one)			on and/or in				ath occurr				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mary P. Howell, M.D., 65-C Thomas Johnson Drive, Frederick, Maryland 21702-4371  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		with Tot com	Σ		-	<u></u>		29c					-		
Mary P. Howell, M.D., 65-C Thomas Johnson Drive, Frederick, Maryland 21702-4371  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	•	1		The second secon	*	1			υ <del>Ϥ</del>	.00/3		ı	NOVELIDE	23	, 2004
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		10		\ \ \					on I	Drive	Fac	odoriole	Mazzz	and (	21702-4271
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								door	A STAN	,					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Death Year **Physician** Catherine 17:22 ΙÌ 15 2004 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Locetion of Deeth 4c. County of Death Examiner PRINCE GEORGES HOSPITAL Prince George's Cheverly If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) 5. Social Security Number 6 Sex **Funeral** Days Year. Months Hours Min 1□ M 21 F 95 Yrs. July 11 1909 Maryland Director 214-36-4090 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Heatih and Menial Hygiene. Important: If item 27 is markad other than "natural", or items 23a or 28a-f ahov any injury or other traumatic avant, the Medical Examinal must be notified at 1⊠Yes 2 No Director MD Prince George's Palmer Park 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7633 Greenleaf Road 20785 U.S.A. Funerai 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔯 No If Yes, Give Saltimore, Maryland 21215-0020 1 ☐ Yes 2 🔯 No Specify: 2 3 N Widowed 4 □ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th Domestic Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henrietta Queen 2 John Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7633 Greenleaf Road Palmer Park, Maryland 20785 of Disposition (Name of Date 20c. Location - City or Town, State Ernest Spriggs/Son 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11/22/04 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Septic Shock Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sepais severe the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Heart Farluse Physician/Medical Decumbra Grade Sacral 23h. Did tobecco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed hes 1 ☐ Yes 2 ☐ No certificate l or Attanding Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No Certification: To After this 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours a To the Funeral C Medical ( Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO061446 11/15/2004 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) KALAISELVI Hospital Drive Cheverly, Maryland 20785 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 1 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 38226 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea **Physician** 1806 M Esther Nivember 14, 2004 Smith /Medical County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner George's Cheverle HOS ecres 5 rince 8. Date of Birth (Month, Day, Year Sept. 30, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days 579-27-0382 74 Yrs 1930 Grand Ba., Ct. Lil Director Usuel Residence of Decedent Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2 No Directo Prince George's Riverdale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 6035 67th P1. 20737 Liberia 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or items 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3X Widowed 4 ☐ Divorced Black "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) 12th College (1-4or 5+) Teacher Education of Health and Mental Hygi item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Boyd Korkoryahn Hawa Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Smith/Son 6035 67th Pl. Riverdale, Md 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages
Department of th
Important: if ite
any injury or of 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery Dec. 4,2004 Brentwood, Md \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature & Funeral Service Licentee Capitol Mortuary Inc. 22. Name and Address of Facility poce 1425 Maryland Ave., N.E. Wash., D.C. 20002 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Atheroscherota Corder V 45 entar **Physician** resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 4☐ Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Pes 2 No 2 R/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Att completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number HUUSS 92-7 30. Name and address of person who co leted cause of death (tem 23a) (Type, Print) 3001 SALVAdor Date filed (Month, Day, Year) 32. Registrar's Signature 1 7 2004 Registrar

**ORIGINAL** 

		State Unpend Item Registrar  1. Decedent's Name (First, Middle,						2. Date of D		-	3. Time of Death
Physician		WARNEBIA CECE	LIA SIMMON	S				Month NOV	Da 1.8	Year 2004	0443 A M
/Medica Examine		4a. Facility Name (If not institution, g		<u> </u>	4b. City, T	own, or	Location of Dea			County of Deat	
		PRINCE GEORGES	HOSPITAL C	ENTER	CF	EVE	RLY			PRINCE (	GEORGES
Funeral		5. Societ Species Number 61	Sex 7. Ag	e (In yrs. last birt	Months	Year Days	If Under 24 Hr Hours Mir	. (Month, L	Day, Year)	9. Birtl	hplace (State or Foreign untry)
Director		Usual Residence of Decedent	10 W 2001	33	Yrs.			SEP. 4	, 19	71 WASI	INGTON, DO
Maryland -f show	1	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
72 hours atter death with the Maryla neturel; or items 23e or 28e-f should be builtied at the hours of the ho	0	MARYLAND PRINCE	GEORGE	CAPTTAI	HEIGHTS	:					1 XYes 2 ☐ No
or 28e-f	runeral Director	10e. Street and Number			10f. Zip (				10g. Ci	tizen of What Co	untry?
23e (	_ _ _ _	1684 BROOK SQUAR	E DRIVE		20	747			UNI	TED STAT	ΓES
lems er m	ne l	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decede If Yes, specif	nt of His	spanic Origin? ( n, Mexican, Pue	Specify Yes or No Rican, etc.)	10-	14. Race - Amei Black, White	
ol., o	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 🔯 If Yes, Give Year or Dates:	No	1 ☐ Yes 2						BLACK
and Mental Hygiene. is marked other then "netureumetic event, Ire Madical To Be Commissed	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a.	Decedent's Usual (Give kind of work life. DO NOT use	Occupa done di	tion uring most of we	orkina	16b. K	(ind of Business/l	industry
Hygiene. ther then " int, the Ma	E I	Elementary/Secondary (0-12)	College (1-4or	5+)					_		
nt. #		17. Father's Name (First, Middle, La	st)	SAK	GENT SEC			ER me (First, Midda		IVATE	
and Mental I is marked of sumetic eve	o ne	EDDIE GAMBLE,	Ť					N SIMMO		i Sumame)	
item 27 is marke other treumetic	=	19a. Informant's Name/Relationship		19b.	Mailing Address (	Street a		-		or Town, State, Z	in Code)
27 r tr		EDDIE GAMBLE,	R./FATHER		09 N. CH				-		1219
item othe	1	20a. Method of Disposition		20b. Place of	Disposition (Name y, crematory or oth	of ner place	a)	Date	20c. L	ocation - City or	Town, State
nent of ant: If if ary or o		1 Burial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Spe			ECTION C			26/04	CLI	NTON, MD	
Department of ries Importent: If item eny injury or othe once.		21. Signature of Funeral Service	ensee Mul	le	22. Name and ALEXAND 5538MAR	Address ER S	s of Facility POPE	FUNERAL	HOMI	ES MD 2	0747
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused by one cause on each li	the death. Do n						. MU _ 2	Approximate Interval Between
ysician i	1	Immediate Cause (Final disease or condition	•	Arrhyth	mia						Onset and Death
ledical aminer		resulting in death)	Hyperte	a consequence o	rdiovasc	n1ar	n Dispas	e Compl	icata	od by	
		Sequentially list conditions	b. Pregnan Due to (or as	су		u	DIDCUL	se compr	TCate	eu by	
Jsit C	l line	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	π):						
burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of	of):						
			d								
as the l	rnysician/medical	=									
for use	200	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2  Fetal death	3 □Ectopic pre	папсу				23d. Date of deli	,
he atte	200	in the past 12 months? 1 X Yes 2 ☐ No	4☐Pregnant at 9☐ Unknown		5 Other (spec					Month	Day Year
detached to		9 Unknown		A - A - Bis - I				1 oo. p:		71 -	10-01
ed be	2	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying cat	ise givei	п іл Ралі.		Yes 2		the cause of death?  bably 4 XUnknown
should t	i ed							11		□No 3□Pro	JUNE OF THE PROPERTY OF THE PR
age 2	Completed							, per	s an opsy formed? 2 \( \sum No	prior to co	opsy findings available ompletion of cause of 2 No
this certifical	บ	25. Was case referred to medical examiner?	. In an italy			-		ath (Check only	one)		
sidi ib la	2	XXYes 2 No	Hospital:		patient 3 DOA		4 🗀 Nursing i			6 □Other (Spec	ify)
r death. actor: After by the funera	eruncanon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat		ry 28b. T y Year) ir	ime of 286 ijury M	S. Injury Work? 1 🗆 Y	at ? es 2 □ No	28d. Describe	now inju	ry occurred	
105		3 Suicide 6 Could not	d 28e. Place of Inj building, et							nd Number or Rui	

29a. Certifier

(Check only one)

NUV Z 4 2004

32. Registrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

> 29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) NOV. 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p

ye

Certification:

Medical

State of Maryland / Department of Health and Mental Hygiene () (1)

3	8	2	2	8
40	~	South	-	40

					,	Certific	cate of	Death		Reg. No.	14 3	0220
	· ·		1. Decedent's Name (First, Middle, La	ist)					2. Date of De Month		Year	3. Time of Death
	Physici /Medic		ASHMEN	SHA	MI	GIF	+N-		NOVEM	BER 14	2004	8:20 p
Ì	Examin		4a. Facility Name (If not institution, give			•		4b. City, Town, or Lo				1
		М	Manor Care- Whea		d	46 1 161	Inder 1 Year	Silver Sp			gomery	
	Funeral Director		578-46-5980	Sex 7. Age 1 □ M 2 1 □ F	(In yrs. last bin	Mor	nths Days	Hours Min.	March 1	th y, Year) 4, 1904	9. Birthplac Country Turk	e (State or Foreign ) ey
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Location	1				10d.	Inside City Limits
	Maryl f sho	ō	Maryland Montgo	omerv	Kens	singto	n					1 ☐ Yes 2 ☒ No
	r 286	Director	10e. Street and Number			10	f. Zip Code			10g. Citizen of V	What Country	?
	h with		3333 University	Blvd. West	, #311		20895	5		USA	1	
	ems (	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U,S.	13. Was E	ecedent of h	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14. Rac	e - American k, White, etc	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or items 23e or 28e-f show any Injury or other treumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🗹 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	)		es ŽÖNo		, ,	Specify		nite
2	natu dical	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Decedent's (Give kind o	Usual Occup f work done	pation during most of work d)	ing	16b. Kind of Bu		-
12	within	qm	Elementary/Secondary (0-12)	College (1-4or 5+	)			d)		Woodwor		-
2	filed v Hygie ther t		17. Father's Name (First, Middle, Last	)		Seams	tress	18. Mother's Nam	e (First, Middle,	Departm Maiden Surnam		ore
ā	d be ental sed o	To Be	Unknown Arslan					Unknov			-,	
37	shoul nd Ma mark	F	19a. Informant's Name/Relationship (	Type, Print)	19b	. Mailing Ad	dress (Street	and Number or Rur		er, City or Town,	State, Zip Co	ode)
ž	alth a 27 is 27 is		Charles Shamigia	an/Son	90	05 Ros	well [	rive, Sil	lver Sp	ring, MC	20901	L
ore.	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Demousl from State	20b. Place of cemeter	Disposition y, crematory	(Name of or other pla	ce)	Date Nov. 15	20c. Location -	City or Town	, State
Ĕ	Pag ment: If		4 □ Donation 5 □ Other (Special		Me	etropo Crema			2004	Alexand	ria, V	/irginia
Baltimore,	permit. Departr Imports any Inj		21. Signature of Funeral Service Lice	nsee		22. Nan Fran	e and Addre	ess of Facility. COLLINS CSITY Blvd	Funeral	l Home I ilver Sp	nc. oring,	MD 20901
		_	23a. Part1. Enter the disease, or com	plications that caused t	he death. Do r	not enter the	mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Ar	oproximate terval Between
1	Physician		shock, or heart failure. List only	one cause on each line							Ö	nset and Death
1	/Medical Examiner		Immediate Cause (Final disease or condition	a	HAL	Am.	IC	HEI	MORY	RHALT	E	
	LAdimine	<u>.</u>	resulting in death)		ue to (or as a				1			
	ted nsit	edicai Examiner		b	TYKE	EKI	FN	SILON	/	101		
	execu al-tra	Exar	Sequentially list conditions, if any, leading to immediate	D	ue to (or as a o	consequence	e of):					
68760,	e be (	cai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	ue to (or as a c	consequence	of):					
× 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	Medi	resulting in death) Last	4	40 10 (0) 40 4 0	onsoquonoc	. 617.					
9 0	s that the death ce ned by the attendi e detached for use	Physician/		u.								
	he de	yslo	Part II. Other significant conditions of	contributing to death but	not resulting in	the underly	ing cause giv	en in Part I.				e cause of death?
P.0	that the ded by detail								10	Yes 2∐No	3 Probab	ly 4 Unknown
Records,	w requires the been signed should be contact.	d by							24a. Was	an autopsy		autopsy findings
ပ္ပ	w req	Sete							perto	rmed?	compl of dea	ble prior to letion of cause ath?
	he law te has age 2	Completed							10	res 210 No	1 🗆 Y	es 2 No
Vital	ician: The certificate rector, pag	BeC	25. Was case referred to medical					26. Place of Deat				
	nysici iis ce I direc	10	examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 ☐ Inpatient	t 2 ER/Ou	tpatient 3[	DOA Oth	4 LUNUISING HO	ome 5□ Resid	dence 6 □Oth	er (Specify)	
0	Attending Physician: or death. sector: After this certific by the funeral director.	::0	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Yea <i>r</i> ) 28b. 1	Time of njury	28c. Injui Wor		28d. Describe I	now injury occur	red	
<u>s</u>	tendi feath. tor: A the fu	cat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b		A11 4-	M		Yes 2 □ No	Opt Leastion (	Strot and Numb	or or Pural D	auta Alumbar
Division of	Hospital or Attend 24 hours after death Funeral Director: / etely filled in by the t	Certification:	4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, fa (Specify)	rm, street, ta	стогу, опісе		City or Tox	Street and Numb vn, State)	er or Hural H	oute Number,
_	spital ours neral		29a. Certifier 1 Certifying Ph	nysician: To the best of	my knowledge	, death occu	rred at the tir	me, date and place,	and due to the	cause(s) and ma	inner as state	ed.
	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical		miner: On the basis of e and manner state	xamination and	d/or investig	ation, in my o	ppinion, death occur	red at the time,	date and place,	and due to the	e cause(s)
	To th withii To th comp	ž	29b. Signature and title of certifier	ſ			29c. Licens	se number		29d. Date signe	d (Month, Day	r, Year)
	6		Shilan	(100	eni		VI	0585	21	NOVEM	BER. 1	5 2004
	(0		30. Name and address of person who	completed cause of dea	ath (Item 23a) (	(Type, Print)	0-0				,	
			31. Date filed (Month, Day, Year)	STNE. 32. Registrar	THT.	SEK	YER	MANE	VIE	200K V	工厂工	MD.
	Sta Registr			004 32. Hegistrar	o orginature	6	park	2				

			For State Registrar	State of	of Marylan	d / Depa <i>Cer</i>	rtment of H <i>tificate of L</i>	ealth and N Death	lental Hyو. ۶	giene 0	04	38229
	Physici		1. Decedent's Name (First, Middle,	·					2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medid		Brenda K.  4a. Facility Name (If not institution,				4b. City, Town, or	Location of Death	Novembe	r 15,20 4c. County		6:30 A. <sup>M</sup>
	?		Bethesda Manor	Care			Bethesd			Montg		
	uneral			5. Sex 1 □ M 2 <del>∏</del> F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Da)	r, Year)		lace (State or Foreign try)
	irector		463-64-7111 Usual Residence of Decedent		61				Jan. 24	1943	Ark	ansas
ırylan	thow Tall	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits  ty⊒Yes 2 □ No
he Ma	288-4 s	ecto	Virginia Fairf	ax	Vie	nna	10f. Zip Code			10g. Citizen of \	Mhat Caus	<b>21.</b>
with	3e or 3	Dir	705 Tapawingo Ro	u 2 bac			22180			USA	vnat Coun	u y :
death	r runs	Funeral Director	11. Marital Status		edent Ever in U.	.S. 13. V	Vas Decedent of Hi Yes, specify Cuba		pecify Yes or No-		e - Americ	
:1 Z 1 S-UU30 within 72 hours after death with the Maryland	Important if them 27 is marked other than "natural", or liams 23e or 28e-1 show any injury or other traumatic avant, it a Medical Examination to other traumatic avant, it a Medical Examination to other traumatic avant.	by Fu	1 Never Married 2 Marrie	d 1 ☐ Yes If Yes, G	21√ No ive No		☐ Yes 2√ No	Specify:	riicari, otc.)	Specify		ite
<b>3-UU36</b> 72 hours af	ntural'		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or I	Jates:	16a. Deced	ent's Usual Occupa	ition		16b. Kind of B		
<b>51.3</b> Airlin 72	Medis	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed,	) (1-4or 5+)	(Give	kind of work done of OO NOT use retired	lurina most of worl	king	Vetera		
A Mile	t. Le	Соп	12			Loan	Specialis	t		Adminis	strat	ion
yland outd be file	ed off	Be	17. Father's Name (First, Middle, La	ist)				18. Mother's Nam		Maiden Suman	10)	
shoute	mark	ို	Gale R. Harris 19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Street a	Mary K and Number or Ru		r, City or Town,	State, Zip	Code)
Mar and 2 sh	27 ls ar trau		Samuel H. Shahee	n/Spouse	2	705 T	apawingo	Road, S.	W., Vier	nna, Va.	2218	30
Saltimore,	r itar	100	20a. Method of Disposition 1 ☐ Burial 2 ☐€cremation 3	3 ∏Removal from	20b. F	Place of Dispos cemetery, cren	sition (Name of natory or other place	g)	Date	20c. Location -	City or To	wn, State
TIM T. Pag	Q of the		`4 □Donation 5 □ Other (Spe	ecify)			tan Crema		17/04	Alexand	lria,	Va.
Den Permi	Impoi any ir once.		21. Signature of Funeral Service Li	censee		22	Name and Address MONEY &	KING FU	NERAL HO	OME, INC		
			23a. Part1. Enter the disease, or	omplications that	caused the deat	h. Do not ente	er the mode of dying	Maple Av g, such as cardiac	e., Vier or respiratory ar	ina, Va. rest,	2218	Approximate Interval Between
Phy	sician		shock, or heart failure. List or Immediate Cause (Final disease or condition	ny one cause on		thero	scle-of.	c dic	P			Onset and Death
	ledical aminer		resulting in death)	a. Due to	(or as a conseq		101001	<u> </u>				
LA		er	Sequentially list conditions, if any, leading to immediate	b	(or as a conseq	uence of):						
pejn	ansit	Examine	cause (Disease or injury that initiated events		(0. 20 2 00.1004							
U,	an an irial-tr		resulting in death) Last	Due to	(or as a conseq	uence of):						
os/6U, reate be executed	physician and s the burial-transit	dicai		d								
Certific	attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregna	ancy				23d Da	te of delive	rv
death certif	e atter	Physician/M	in the past 12 months?	4□Preg	birth 2 Teta nant at time of d		Ectopic pregnancy Other (specify)			Мо		Day Year
at the C	by the	hys	9 🗆 Unknown	9□ Unk								
	been signed by the s should be detached	þ	Part II. Dther significant condition	is contributing to	death but not res	ulting in the ur	iderlying cause give	en in Part I.		obacco use cont 'es 2 □ No		e cause of death?
OT VITAL HECORDS, Physician: The law requires t	been should	Completed	F00-						24a. Was			osy findings available
He a	certificate has ti irector, page 2 s	duic	100-	- OILE					autop perfor	med?	prior to con death?	npletion of cause of
Ital	rtificat tor, pa	Be C	25. Was case referred to medical					26. Place of Dea			1 1 1 1 1 1 1 1	2   140
OT V	his ce al direc	P	examiner? 1 Yes 2 Mo			ER/Outpatien		4 Nursing H	ome 5 Resid			)
P ding	After 1 funera	ion:	27. Manner of Death  1 ZNatural 5 ☐ Pending 2 ☐ Accident investiga		of Injury nth, Day Year)	28b. Time of Injury	28c. Injury Work	rat ⟨? Yes 2 □ No	28d. Describe h	low injury occuri	red	:
DIVISION I or Attanding	octor:	fical	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Plac	e of Injury - At h	ome, farm, str	eet, factory, office				er or Rura	Route Number,
is c	al Dire	Certification:	4 Homicide	Dulle	ding, etc. (Specif	····			City or Tow	m, state)		
Hospi	within 24 yours are locau.  To the Funeral Director: After this certifice completely filled in by the funeral director, p	Medical	29a. Certifier 1 Certifying (Check only one)	xaminer: On the	ne best of my kno basis of examina nner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my op	e, date and place, pinion, death occur	and due to the or red at the time, or	cause(s) and ma date and place,	inner as st and due to	ated. the cause(s)
To tha	To the	Me	29b. Signature and title of certifier	1-			29c. License	number		29d. Date signe	d (Month, i	Day, Year)
	_		> / Million	7	Phy	YSTCTC -	Do	055694	/	Nove	rice -	15,2004
ľ	0		30. Name and address of person w	M THUZ	use of death (Item 4000	Olney	- Laytons	ville Ro	1 014	ey, MD	> 20	835
	Sta Regist		31. Date filed (Month, Day, Year)		Registrar's Signa	ature #	Sporks					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** рМ 14, Van Gasken November 2004 6:40 Schrider /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bedford Court Nursing Home Silver Montgomery If Under 2 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 K□ F Yrs. 98 Director Nov. 12, 1906 Pennsylvania 216-44-3974 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits i Hygiene. other than "natural", or Itams 23a or 28a-f show vent, the Medical Examinar russt be notified at 10a. State 1 ☐ Yes 2 ☐ Mo Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3700 International Drive, #155 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White ð 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Archivist U.S. Government imit. Pages 1 and 2 should be flik spartment of Health and Mental Hy portant: If item 27 Is marked oth y injury or other traumatic event 92. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Harry Van Gasken Cora Seitzinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Schrider/ Niece 1571 Ivystone Court, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If itel November 17 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 4 Donation 5 Other (Specify) 2004 Silver Spring, Maryland Cemetery 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. any ir 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Vascular Accident /Medical Due to (or as a consequence of): Examiner Generalized Arteriosclerosis Sequentially list conditions, if any, backing to influed at cause. Enter Underlying Cause (Disease or injury that influed events. Due to (or as a consequence of) Examine that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death 1 Live birth for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I detached 9 Unknown s baen signad by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 1 Yes 2 🔀 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 2X No XX Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? completely filled in by tha funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: After Injury 5 Pending 1 X X atural al or Attendin after death. I Diractor: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \( \text{Homicide} \) To the Hospital o within 24 hours aft To the Funeral Di \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D1104 η November 15, 2004 ss of person who completed cause of death (Item 23a) (Type, Print) John B. Umhau, 8805 Connecticut Ave., Chevy Chase, MD 20815 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 16 2004 Registrar

			For State Registrar	State of Mar	yland / De	epartment of H Dertificate of I	leaith and iv Death		ene UUL	38231
	Physicia	an	1. Decedent's Name (First, Middle, Las		_			2. Date of Death Month	Day Year	3. Time of Death
	-/Medic			chard Seel	ey	# Ch T	Location of Death	Novembe:	r 10, 2004 4c. County of Dear	
	Examin	er	4a. Facility Name (If not institution, give 2050 Potts Point			Hunting			Calver	
r	Funeral		5. Social Security Number 6. Se	7. Age (/	n yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign puntry)
	Director		071-32-6210	<b>X</b> M 2□ F	46 y	rs. Months Days	Hours Min.	June 23	, 1958 C	alifornia
	and w		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town	or Location				10d. Inside City Limits
	Maryi -f sho	tor	MD Cal	vert	Huntin	ngtown				1 ☐ Yes 2X No
	th the	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	23a c	ralD	2050 Potts Point				0639		USA	
	er des Itams	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ▼No	er in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
2	urs aft	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: W	hite
	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(	Decedent's Usual Occup	during most of work	ing 1	6b. Kind of Business	Industry
4	vithin ne. han *	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retired Etware Engir	1)		Defense Co	ntractor
2	filled v Hygie thar t	ပ္ လ	17. Father's Name (First, Middle, Last)	<u>5+</u>	501	tware raigin	18. Mother's Name			incrac cor
0	ld be ental kad o	To Be	Joseph	S	eeley		Margar	et	S	Seaton
aly	shou and M s mar	_	19a. Informant's Name/Relationship (7	ype, Print)	19b. I	Mailing Address (Street	and Number or Run	al Route Number,	City or Town, State, 2	Zip Code)
, A	and 2 ealth a m 27 I		Kelly Seeley (wi			0 Potts Po				20639
2	ages 1 nt of H :: If itae		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		Disposition (Name of crematory or other place cenatory)	Novel 20		Oc. Location - City or Clinton,	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If time 27 Is marked other than "natural", or items 23a or 28a-f show important: If time 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exacult or items the notified at once.		° 4 ☐ Donation S ☐ Other (Specify 21. Signature of Fureral Service Licen		Tiee CI	22. Name and Addres	1			
ž	Depar Depar Impo any ir 2002		Gary			8125 South				
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	e death. Do no	Stumes	g, such as cardiac	former	st,	Approximate Interval Between Onset and Death
H	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c			( ) !	10)100		
	Examiner		Companie II a list age divisor	b	7	,.				
_	P ::	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	onsequence of	n):				
	xecute and II-trans	Examiner	that initiated events resulting in death) Last	cDue to (or as a c	onsequence of	i):				
00/00	The taw requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical E	(	d						
0	rtificat ng phy as th	-	IE SCHALE.							
2	ath ce ttendii or use	lan/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 (	Fetal death	3 □Ectopic pregnancy			23d. Date of del Month	livery Day Year
	tanding Physiclan: The taw requires that the death cer leath. Ior: After this certificate has been signed by the attendin the tuneral director, page 2 should be detached for use	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne of death	5 ☐ Other (specify)				
	s that ned by	by Ph	Part II. Other significant conditions of	ontributing to death but r	not resulting in	the undertying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
200	en sig	ed t				-		1 🗌 Yes	s 2 <b>∑N</b> o 3□Pr	robably 4 Unknown
ני	taw ri as be	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u> </u>		Con							No 1 □ Yes	2 No
VII	siclan certifi rector	o Be	25. Was case referred to medical examiner?	Hospital:		ontingt 20 DOA Oth	00	h (Check only one		-:6.1
5	Attanding Physiclan: or death. actor: After this certifici by the funeral director.	<b>-</b>	1 ☐ Yes 2 No  27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury (Month, Day Y	28b. Ti	me of 28c. Injur	y at	28d. Describe hov	nce 6 Other (Spe w injury occurred	city)
200	ttanding death. ctor: Aft	atlo	Accident     S □ Pending investigation		ear/ m	ury Wor M 1 🗆	Yes 2 □No			
2		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farr 'Specify)	m, street, factory, office		28f. Location (Str. City or Town,	eet and Number or Ro State)	ural Route Number,
_	spital		29a. Certifier 1 Certifying Ph	ysicien: To the best of a	ny knowledge,	death occurred at the tin	ne, date and place,	and due to the car	use(s) and manner as	s stated.
	To the Hospital or At within 24 hours after o To tha Funaral Dirac completely filled in by	edical	(Check only 2 Medicel Exen	niner: On the basis of ex and manner state	camination and	or investigation, in my o	pinion, death occur	red at the time, da	te and place, and due	to the cause(s)
	Withi To t	Σ	29b. Signature and title of certifier			29c. Licens		29	d. Date signed (Mont	h, Day, Year)
			,	0/	h //h = 22 \ \		33123		11-12-6	7
	15		30. Name and address of person who Jonathan Lowenth			Type, Print) tal Road P.	rince Fre	derick,	MD <b>2067</b> 8	
	Sta Registr		31 Date filed (Month Day Year)	5 2004	Signature					
	registi	CII	1100 T	- LUUTF CO	TERRED 1	C. MINING				

State of Maryland / Department of Health and Mental Hygiege Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 12:00 P<sup>M</sup> November 12, 2004 Lucila Norma Santos /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Spa Creek Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) CA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2 ☐XF 74 Yrs. 548-46-8363 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Prince Georges Bowie 1X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ "natural", or Itams 23a 2902 Tapered Lane 20715 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bartolome Losada Ramona Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Rohde/ Daughter 12015 Ivy Mill Road Reisterstown, MD 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Huntt Crematory 11/15/2004 Waldorf, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Furral Service Licensee 16000 Annapolis Road Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ohshahi Physician Chrow! disease or condition resulting in death) (c .m /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2 No To the Hospital or Attanding Physician: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4=Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Exertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 21UPD.Dar Year) 32. Registrar's Signature State Registrar MOV 1 5 2004

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** Nov 21, 2004 **James** Thompson 11:15 pm Robert /Medical 4b. City, Town, or Locetion of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Allegany Cumberland Devlin Manor Nursing Home If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex Funeral Hours 1□ M 2□ F Mar 20, 1922 Director 216-18-1706 82 permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No MD Allegany Oldtown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21555 USA 20200 Oliver Beltz Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No KYes, Give Year or Dates: WW II 1 ☐ Never Married ※☐ Married 1 Yes X No Specify: δ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 laborer Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel Thompson Rose Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) wife 20200 Oliver Beltz Road Oldtown MD 21555 Gail Thompson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/24/2004 Flintstone Rocky Gap Veterans Cemetery MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. MYOCARDIAL INFARCTION /Medical Immediate Cause (Final disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed ACCIDENT SEVERE OBSTRUCTIVE LUNG DISEASIZ 1 ☐ Yes 2 ☑ No HRUNIC 1 ☐ Yes 2 7 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: this funeral i Director: After the din by the funeral death. filled in by within 24 hours a

To the Funeral C

completely filled

Baltimore, Maryland 21215-0020

**Physician** 

**Examiner** 

attending physician end for use as the buriel-transit

been signed by the s should be detached

The law requires that the death certificete be executed

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



lanza

1321.

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

Unpend Item 23a,27,28a I per me Gostificate of Department of Health, and Mental Hygien 00 1 38234

							C	en	ificate	e of	Death			Reg. No.		
	Physicia /Medic		1. Decedent's Name (Fit Lowell		Last)	V	ennar	i	-	Tho	mas		2. Date of De Month NOV •	eth Day 22, 2	Year 2004	3. Time of Death 2115 PM
	Examine		4a Fecility Name (If not 609 PATT			ımber)					_	own, or Lo SERLA	ocation of Deeth		nty of Death LEGANY	
0	Funeral Director		5. Social Security Numb 530 - 38 - 916		Sex 10∭ M 2□ F	7. Age (In ye	rs. lest birtho		If Under Months	1 Year Days		24 Hrs. Min.	8. Date of Bir (Month, Da 05/23/	th (951	9. Birthp Coun Sout	lace <i>(Stat</i> e o <i>r Foreign</i> hry) Dakota
	2		Usuel Residence of Dec			140	O: T		- •*							04 1-14-05 11-5-
	Marylar n-f show	ţo		b. County Alleg	any	10c.	City, Town o		land						1	0d. Inside City Limits 1 Y Yes 2 □ No
	r 28	<u>8</u>	10e. Street end Number	r					10f. Zip	Code				10g. Citizen	of What Cour	ntry?
	3a o	-	609 Pat	terso	n Avenue					2:	1502			USA		
0	be filed within 72 hours after death with the Maryland ntal Hygiane.  Id other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Maritel Status 1 ☐ Never Married		12. Was Dec Armed F	edent Ever in orces? 2\D\No	U,S.				Hispenic Or ban, Mexical Specify:		ecify Yes or No Rican, etc.)		Bace - Americ Black, White,	etc.
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212	than than	Ē	Elementary/Secondar 12	ry (0·12)	College	(1-4or 5+)		Sel	f-Em	ploy	yed			Home	e Impr	ovement
Maryland 21215-0020	e da la Be	å	17. Father's Name (Firs. Clayton	t, Middle, La		homas	'					er's Name	e (First, Middle, Be 1			nnard
<u> </u>	2 should and Man la marke sumetic	၉	19a. Informant's Name/	/Relationshi	(Tyne Print)		19b N		Address	(Street	t and Numb	er or Run	el Route Numb	er. City or Toy	wn. Stete. Zip	Code)
Ma			Leslie A.			e		_					Cumber			502
	1 and 2 Health em 27 I	-	20a. Method of Disposit				Place of D					1	Date		on - City or To	wn. State
Š	iges if it		1 ☐ Burial 2 🗖 Cr	remation 3			cometery, umber					11/1	28/2004			
ij	nit. Pa artmen ortant: injury	- 8	4 □ Donation 5 □				umber.						ams Fam			
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any injury or other to once.		21. Signature of Funera	LC.	Adm	-1			404	Dec	atur S	Stree	et, Cum	berlan		
			23a. Part1. Enter the di shock, or heart fai	isease, or co	omplications that	caused the de	ath. Do not	enter	the mode	e of dyi	ing, such as	cardiac	or respiratory a	rrest,	1	Approximate Interval Between
· 参	Physician /Medical Examiner	ıer	Immediate Cause (Fina disease or condition resulting in death)		e. <u>Meth</u> a	adone j		cat	tion						3 1 7 1	Onset and Death
	certificate be executed nding physician and use as the burlal-transit	n/Medical Examiner	Sequentially list condition if eny, leading to immediate	ons, diate	b	Due to	(or es a cor	nsequ	ence of):							
68760,	sate be e shysiciar the burk	dical	Sequentially list condition if eny, leading to immediate cause. Enter Underlyin Cause (Disease or injurthat initieted events resulting in deeth) Last	<sup>19</sup> <b>1</b>	C	Due to	(or as a cor	nseque	ence of):						1	
ŏ		an/Me			<b>d</b>											
, P.O. B		y Physicia	Part II. Other significan	t condition	s contributing to o	leath but not r	esulting in th	ne und	derlying ca	use gi	ven in Part	l.		tobacco use Yes 2□ No		the cause of death?
Vital Records,	w requires s been sign s should be	Completed by												an autopsy rmed?	ava	ere autopsy findings ailable prior to mpletion of cause death?
æ	The law ate has page 2	E											10	Yas 2 No	18	¶es 2□ No
a			25. Was case referred t	to medical							26 Place	of Deat	h (Check only o	i		
5	Physician: this certific ral director,	e e	examiner?	io modiour	Hospital:	Inpatient 2	☐ ER/Outp	ationt	3□ DO	, Ot	hor:		me 5□Resid		Sther (Specifi	AT SCENE
ō	£	۵ ۲	27. Manner of Deeth		28e. Date	of Injury	28b. Tim			Bc. Inju			28d. Describe			
o	ding F h. After funer	후ㅣ		☐ Pending investiga	non e	2 <sup>h</sup> <b>64</b> Year)	9:10	ry	M		ork? ]Yes 2 <b>1∑</b> 7	No			u.i.	ic.
<u>S</u>	or Attending after death. Director: After I in by the fune	<u></u>		Could no	t be Counc	e of Injury - At	foun					_	28f. Location (	Street and Nu	mber or Rure	Route Number.
Division	after Dire Jin b	Certification:	4  Homicide	determin	_ build	ling, etc. <i>(Sp</i> e <b>1 at h</b> o	city)						Cumber 1			
_	Hospi 24 hou Funer Funer ataly fill	edicai C	29a. Certifier 1□ (Check only 2□ one)	Certifying Medical Ex	Physician: To the	e best of my k	nowledge, d	leath o	occurred a	at the ti	ime, date ar opinion, dea	d plece,	end due to the	cause(s) and	manner as st	tated.
	To the within 2 To the compla	Me	29b. Signature and title	of certifier	a.iu iiidi				29c.	. Licen:	se number			29d. Date sig	ned (Month,	Day, Yeer)
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			1/1	200	100 11	1/2	7	حر	ري							
			30. Name and address	or person wi	no completed cau	se of death (If		pe, P Peni	,	reet	t. Ral	tim	ore, Mai	vland	21201	
	- X-2		31. Date filed (Month, C	lay Voor	( Ffuf	Registrar's Sig				-	-, Du		Lej ikil	.,		
0.0	Stat Registra	C	51. Date filed (Month)	EC 0 2	2004	Depar	-av	19	1	ino.	W.			i-		

State of Maryland / Department of Health and Mental Hygiene 38235 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** THOMPSON MARTHA 2004 6:59Am 11 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Under 24 Hrs. 8. Date of Birth (Month, Day, Year) THE LAKE CASTAL HOSPICE AT WICOMICO If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) MONTEGO 6. Sex **Funeral** 1□ M 2 F Months Days 092644521 Yrs. -13-1952 BAY JAMAICA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other tran matter the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1ÆYes 2□No **Funeral Director** DALISBURI WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT 3C 804 SHUMAKEA 21804 USA DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Š BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PROGRAM ASSISTANT UMES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SYDNEY INEZ HAMILTON LHOMPSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KINGSTEN 19a. Informant's Name/Relationship (Type, Print) Date 20c. Location - City or Town, State 5 HRMOUR GLADES MYACINTH DACOSTA~ SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 11/20 04 DECATUR 4 ☐ Donation 5 ☐ Other (Specify) KENEW MEMORIAL 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BENNIE SMITH 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) Concer /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) aor: Atter this certificate has been signed by the a the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes (No 3 Probably 4 Unknown Š 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 22 No 1 ☐ Yes f or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Dhpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 2 Accident 1 Yes 2 No Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scolist ND M 0 CUX DAVID COURLY, 31. Date filed (Month, Day, Year) NOV 15 2004 32. Registrar's Signature State

Registrar

			1 - Stete Registrar	State of Maryla				nental Hyg	eg. No2 0	04	38236
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last)     Vivian Blanche  4a. Facility Name (If not institution, give si	Taylor		4b. City, Town, o	r Location of Death	<del></del>	Day 2004	Year 4 of Death	3. Time of Death 7:00 p M
44.	Funeral	101	1700 Lebanon Stree  5. Social Security Number 6. Sex	t	s. last birthday) Yrs.		sville	8. Date of Birth (Month, Day, March 25	Princ	9. Birthpla	orge's
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23c or 28a-f show any injury or other traumatic event, the Medical Examinational be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Ge  10e. Street and Number  1700 Lebanon Street	t  2. Was Decedent Ever in Amed Forces?  1 \( \superscript{Yes} \) 2 \( \superscript{M} \) No If Yes, Give Year or Dates:  ation completed)  College (1-4or 5+)  e. Print)  moval from State  Me	16a. Dece (Give life.) Elec	11e  10f. Zip Code 20783  Was Decedent of Ff Yes, specify Cubit of Feet Sund Occup, kind of work done DO NOT use retired tronic Asing Address (Street Lebanon sition (Name of natory or other platan Cremat.	sation during most of work of work of the sembler  18. Mother's Nam  Carolyn and Number or Run  Street, I	ecify Yes or No-Rican, etc.)  ing  e (First, Middle, Marpe al Route Number, Tyattsvi Date 0/2004 ch's Fun	Og. Citizen of V U.S.A.  14. Race Blac Specify 16b. Kind of Bu Litton Maiden Surnam City or Town, Lle, Ma: 20c. Location	what Country America A	d. Inside City Limits  1 Yes 2 No  ny?  In Indian,  tc.  te  sstry  stries  Code)  d 20783  m, State  Virginia
	rate be executed / Medical   Medical	Examiner	23a. Part1. Enter the disease, or compile shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last	ations that caused the deap cause on each line.  Acute Myoca  Due to (or as a conse	equence of):			or respiratory arre	ost,	1	Approximate Interval Between Onset and Death Onset Hour
P.O. Box 68760,	t the death certific by the attending p ached for use as	Physician/Medical	d.  IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  Part II. Other significant conditions conti	c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3 death 5	Ectopic pregnancy		22a Did tob	Mon		ay Year
Vital Records,	w requires that been signed I should be det	eted by	Diabetes Mellitus	Type 2	suiting in the ur	raenying cause giv	en in Part I.	1 □ Ye	s 2∭No	3 🔲 Probat	cause of death?
al Rec		e Completed	History of Breat (	Jancer					ned? de	rior to comp eath?	y findings available pletion of cause of
of	ling Phys n. After this funeral di	To B	eyaminer?	spital: 1 ☐ Inpatient 2 [ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Wor	4 🗆 140/3//19 110	me 5 X Reside 28d. Describe ho	nce 6 Othe		
Division	ire n b	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre ify)	eet, factory, office		28f. Location (Str. City or Town,		r or Rural F	Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	(Check and 2 Medical Examina	cien: To the best of my kn er: On the basis of examin and manner stated.	nowledge, death action and/or inv	estigation, in my o	pinion, death occurr	ed at the time, da	te and place, a	nd due to th	ne cause(s)
		~	29b. Signatule and title of certifler	conve	lln	D0383			ovember		
R	6	,	30. Name and address of person who com  David Cromwell, MI  31. Date filed (Month, Day, Year)		rsity B	*	., Silver	Spring,	Maryla	nd 20	903
18	Sta Registi	40 4	NOV 1 7 2004	The gistral's sign		de la					

			For State Registrer	State of I	Maryland / D	epartmer Certificat				-		04	38237
	Physici	an	Decedent's Name (First, Midd	-, -, ,		w1	C			2. Date of De	Day	Year	3. Time of Death  10:40p M
	/Medic		George 4a. Facility Name (If not institution	Wille		renley,		Location of	of Death	Novembe		y of Death	<u> </u>
	Examin	ier	Montgomery Gen			01n						gomer	
	Funeral Director		5. Social Security Number		Age (In yrs. last birth		r 1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da March	h y, Year) 7 - 1913	9. Birth Cou Wash	place (State or Foreign intry) ington, D.C.
70			<b>220 40 6163</b> Usual Residence of Decedent		31					TRICIT A	, 1713	MEDII	116011,200
the Marylan	28a-f show	Director	10a. State 10b. County  Maryland Mont  10e. Street and Number	gomery	10c. City, Town	Spring	Code				10g. Citízen of		10d. Inside City Limits 1 ☐ Yes 2 No
with	3a or	흐	18100 Slade Sc	ebool Road		101. 24		860				USA	indy:
21215-0036 ed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinat must be rediffied at once.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar  3 ★★Widowed 4 □ Divorced	12. Was Decede Armed Force 1 ☐ Yes 24	es:	13. Was Dece If Yes, spe 1  Yes	dent of Hi cify Cuba	spanic Ori n, Mexican Specify:		pecify Yes or No Rican, etc.)		ice - Ameri ack, White, ify: <b>Wh</b>	ite
<b>215</b> 21 72	n na Medis	plet		est grade completed)  College (1-4)	(	Give kind of wo life. DO NOT u	rk done a	during most	t of worl	king	TOD. TAING OF	34011100411	idostry
212 g wit	giene er tha	E O	12	College (1º44		olice C	ffic	er			Washin	gton,	D.C.
ind be	d oth	Be	17. Father's Name (First, Middle,							ne (First, Middle,			
Maryland	d Men narke natic	၉	George Washing  19a. Informant's Name/Relation:		106	Anilina Addron	/Street			Florence			- Codel
Mal	27 Is r traur		George W. Tenl			-				ey, Mary		2083	_
Baltimore,	of Heal		20a. Method of Disposition  1   Burial 2 □ Cremation	-	20b. Place of I		me of			Date	20c. Location	- City or T	own, State
tim Pa	dury in the nate of the nate o		' 4 □ Donation 5 □ Other (	Specify	Cedar					8/2004		_	laryland
Bai	Depar Impor any in		21. Signature of Funeral Service	Licensee						es Rinal			Home ing,MD20904
1	Medical xaminer transit	cal Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute Due to (or Corona Due to (or c.	Myocardia as a consequence of ary Artery as a consequence of	Diseas		n					Interval Between Onset and Death
	e attending i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 □ No 9 □ Unknown		n 2 □Fetal death t at time of death	3 □Ectopic p 5 □ Other (s <sub>t</sub>						ate of deliv	ery Day Year
ords, P.O	been signed be should be det	þ	Part II. Dther significant conditions of the Pneumonia	ions contributing to deat	h but not resulting in			en in Part I.					the cause of death?
Vital Record sician: The law requir	8 0	ompleted	Stroke							24a. Was autop	an 24b.	Were auto	opsy findings available ompletion of cause of
Rec		Com	Congestive H	oort Failur	0					perfo	med? 2-√2 No	death?	
of Vita Physician:	this certificate al director, pag	Be	25. as ca referred to medica examiner?	al Hospital:			Otho			th (Check only o			
₽ ç	this ral dii	n: To	1 ☐ Yes 2X No  27. Manner of Death	28a. Date of I	atient 2 ER/Outp		DA Oute 28c. Injury Work	at	ırsing Ho	ome 5 Resid			fy)
Vision	or: Af he fur	atlo	Z	tigation		М		Yes 2□	No				
<b>=</b> 5	after death Director: I in by the	ertification:	3 Suicide 6 Could 4 Homicide determ	mined 288. Place of	Injury - At home, farr , etc. (Specify)	n, street, factor	y, office			28f. Location (S City or Tow		ber or Run	al Route Number,
The Hospital	4 hours Funeral	edical C		ing Physician: To the be I Exeminer: On the basi and manner	s of examination and								
Tot	within 2 To the complet	M	29b. Signature and title of certific	er		29	c. License				29d. Date sign		
	8		) un C	- 6			BC69	92039			Novembe	r 14,	, 2004
	_		30. Name and address of person	•	of death (Item 23a) (T	ype, Print)							
			Matthew J. Co							1005 05	2.5		1 20176

1- State of Maryland / Department of Health and Mental Hygiene 1 - State Amend Items 28a-f per ME, G838 Certificate of Death 38238 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Daniel Ferdinand Urbanek, Jr. 9 2004 Nov 4.32 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7830 Schooner Drive Lusby Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, August 21 **Funeral**  Birthplace (State or Foreign Country) 1 M 2 F 217 60 6068 Yrs Director 53 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "naturel; or Items 23a or 28e-f show eny injury or other than the mental terminal terminal terminal terminal terminal terminal terminal terminal terminal many injury or other traumatte event, the Medical Examination and the modified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7830 Schooner Drive 20657 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Distributor Washington Post 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Ferdinand Urbanek, Sr. Virginia Frances Hancock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita M. Urbanek - wife 7830 Schooner Drive Lusty, Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Calcutta Cerretery November 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Pleasants County West Virgina 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home Port Republic MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Self IN Flicted Physician 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or): Examiner death certificate be executed as the burial-transit TON APPROVED BY MEDICAL EXAMINA that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. attending physiciar Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the ☐Yes 2☐No 9 Unknown 9 Unknown signed by t The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Récords, þ 1 Yes 2 ₩ NO 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No page 1 Yes Physicien: 25. Was case referred to medical examiner?

1 16 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Life Sence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28a. Date of Injury (Month. Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospitel or Attending 1 Natural 5 Pending after death.

Director: Affin by the fur 11/09/2004 1 ☐ Yes 2 🛣 No investigation 16:20 Self inflicted gunshot wound 2 Accident 6 Could not be determined 3 Duicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide home 7830 Schooner Drive, Lusby, MD within 24 hours a To the Funerel C edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Leadical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200)4 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Raymon A. Noble, M.D. 32 Cox Road Huntingtown MD 20639 31. Date filed (Month, Day, Year, 32. Registra Signature State NOV 2004 Registrar

			For State	State of Ma	aryland / D	epartm	ent of H	ealth and			004	38239
			Registrer  1. Decedent's Name (First, Middle, La:	st)			ate of L	- Calli	2. Date of Dea	Reg. No.		3. Time of Death
	Physicia		EMMA RUTH		Į				November 1	Day	23 <sup>Yeer</sup> 2004	
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. (	city, Town, or	Location of De			County of Death	
	Examin	er	Kline Hospice Ho				Mt. Ai				Frederio	
	Funeral		5. Social Security Number 6. S		e (In yrs. last birth		nder 1 Year	If Under 24 H	rs. 8. Date of Birt	h	9. Birth	place (State or Foreign
	Director		254-14-7304	□M 2\\ F	83 Y	rs. Mon	ths Days	Hours M	in. (Month, Da)	22,19	921 Geo	intry) Orgia
	P.		Usual Residence of Decedent									
	aryla/ show	_	10a. State 10b. County		10c. City, Town							10d. Inside City Limits 1  1  1  1  1  1  1  1  1  1  1  1  1
	Ba-f	Directo	Maryland Freder	ick	Frede							
	death with the Maryland rms 23a or 28a-f show rmust be notified at	Ē	10e. Street and Number 805 Blakely Court	#358		101	Zip Code 21702			10g. Citiz	en of What Cou	intry?
	eath	Funeral		12. Was Decedent I	Ever in U.S.	13 Was D			(Specify Yes or No-	. 1	USA 4. Race - Ameri	can Indian
_	Item Item Ineri	un.	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces?		If Yes,	specify Cubai	n, Mexican, Pu	ierto Rican, etc.)		Black, White	
12-0036	d within 72 hours after death with the Marylan jiene. r than "natural", or items 23e or 28e-4 show r than "natural" be rollified at Ite Medical Exercites must be rollified at	by	3 X Widowed 4 Divorced	tf Yes, Give Year or Dates:		1 □ Ye	s 2X No	Specify:		5	Specify: [	√hite
ş	2 hou	ted	15. Decedent's Ed		16a. l	Decedent's	Jsual Occupa	ition		16b. Kin	d of Business/Ir	ndustry
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ylan	should be nd Mental marked o	٦	Gordon H. Drane						bell Cobb			
Mar	2 sh and is m raum		19a. Informant's Name/Relationship (	**					Rural Route Numbe			
	es 1 and 2 should bot Health and Ment fitem 27 is marked r other traumatic		Vicki Willms/daug	nter	20b. Place of		Committee of the Commit	oad, My	ersville,		y⊥ano. ∠. cation-CityorT	
altimore,	Pages nent of B int: If ite		1 XBurial 2 ☐ Cremation 3 ☐		cemetery	, crematory	or other place		1		•	
	it. Pa rtmer rtant njury		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signatury of Fureral Service-Liceral</li> </ul>		West V		and Addres		-29-2004		anta, G	
g	permit. Pages Department of B Important: If ite any injury or of		21. Signatur of total service Liber	him				neral			n Street 11e, MD	
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	Physician /Medical		disease or condition resulting in death)	a. Due to (or as:	a consequence of	6).	COU	ncio				Je many
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	nd ransi	Examin	that initiated events	c								
Ď	be executed ician and burial-transit	Ä	resulting in death) Last	Due to (or as	a consequence of	1):						
Q/8	ate hys	dlcal		d							_	
×	ding l	<b>O</b>	IF FEMALE:	23c. If yes, outcome	of pregnancy						Od Data of data	
X Q Q	leath certific attending p	Physiclan/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectop 5 □ Othe	ic pregnancy			23	3d. Date of deliv Month	Day Year
oj.	the d y the sched	ysi	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9□ Unknown			(0,000,000)					
T	The law requires that the death certifi sie has been signed by the attending page 2 should be detached for use as	by Pt	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in	the underlyi	ng cause give	n in Part I.	23e. Did to	bacco us	e contribute to t	he cause of death?
ĕ	quire on sig uld bu	pq pa	Emply sen	19					_ 1 □ Y	es 2	No 3□Prol	bably 4 Unknown
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	The la	E O							<ul> <li>autop perfor</li> <li>1 ☐ Yes</li> </ul>	med? 2.□•No	death?	empletion of cause of
VITal		Φ	25. Was case referred to medical					26. Place of D	Death (Check only or			55-11
OT <	Physician: The law this certificate has t ral director, page 2 s	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Out	patient 3	DOA Othe	r: 4 🗆 Nursing	g Home 5 ☐ Resid	ence 6	Other (Speci	m as ski
	ng Pi fter ti		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Ti	me of jury	28c. Injury Work	?	28d. Describe h	ow injury	occurred	2003
<u> </u>	tendi leath. tor: A the fo	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b			М		′es 2 □ No				
DIVISION	or At after of Direction by	Certification;	4 Homicide determined	28e. Place of Into	ury - At home, fari c. (Specify)	n, street, fa	ctory, office		City or Tow	n, State)	Number or Hur	al Route Number,
	Hospital or Attending t4 hours after death. Funeral Director: After tely filled in by the fune		29a, Certifier 1 Certifying Ph	ysician: To the best of	of my knowledge.	death occu	red at the tim	e date and pla	ace, and due to the o	ause(s) a	and manner as s	stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exer	niner: On the basis of and manner sta	examination and	or investiga	tion, in my op	inion, death o	ccurred at the time, o	date and p	place, and due t	o the cause(s)
	To th withir To th comp	ž	29b. Signature and title of certifier	$\Omega$			29c. License	number	2	29d. Date	signed (Month,	Day, Year)
	-		> Xd M	NILIA			()	2210	1	ww	in 24;	2004
	4		30. Name and address of person who	completed cause of d	eath (Item 23a) (T	ype, Print)			1		und;	
	,		Llyd HAL	war W	7,19	75 /	eng	W.	treseri	CL	mol ;	1100L
	Sta Registr		31. Date filed (Menth, Day, Year)	2 Hegistra	ar's Signature	A.	and 1					
	3				M	- Jan	men 21					

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 4 Certificate of Death MEND ITEM #28.6 PER ME G838 12/02/04 JH 2 Date of Deeth Month November 23, 2004 **Physician** 714 am EARL RICHARD VAUGHN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street end number) Examiner 4 Church Road Taneytown If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys MAR. 26, 1928 76 Director 213-24-9686 MARYLAND Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside Cit<sup>®</sup> Limits r than "natural", or items 23a or 28a-f shorten Medical Examiner must be notified at 11X Yes 2 □ No Director FREDERICK THURMONT 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 15 LOMBARD ST. 21788 U.S.A. Funeral Peges 1 and 2 should be filed within 72 hours efter death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status Black White etc. TYes 2□No 1945 Yes. Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Year or Dates 1946 Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRUCKING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WILLIAM VAUGHN CARRIE WANTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) thealth item 27 is MILDRED VAUGHN/ WIFE 15 LOMBARD ST., THURMONT, MD. 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State NEW ST. JOSEPH'S 11/27/04 EMMITSBURG, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727-0427 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate nterval Betwe Onset and Death **Physician** Multiple i'n juries /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Physician/Medical Examiner nding physician end use as the bunal-trensit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown <u>چ</u> ate has been sign page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 2 Yes 2 No 1XYes 2□ No 25. Was case referred to medical 26. Place of Death (Check only one) 8 Other:  $_{4\square}$  Nursing Home  $_{5\square}$  Residence  $_{6}$  Nother (Specify) at SCCNC 1X Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject Pinned between frick and condition (Street and Allert and 1 Natural 5 Pending 1X Yes 2 □ No 23/04 death. 2 Accident investigation Formel 7:05 Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. filled in by 4 - Homicide within 24 hours after To the Funeral Dire loadily dack 4 Church Rd. Tanytown, Md. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie OCME November 24, 2004 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Z-JBIULLA 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

DEC 02 2004

		State of Maryland / Department of Health and Mental  1 - State Registrar  Certificate of Death	711	04 38241
Physic		1. Decedent's Name (First, Middle, Last)  2. Date of Month  Frank Leroy Violett  North	of Death Day	3. Time of Death
/Med Exam Funera Directo	iner I	4a. Facility Name (If not institution, give street and number)  Calvert Memorial Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24 His. 8. Date of Months   Days   Hours   Min. (Month)	4c. Count Calv	y of Death  Pert  9. Birthplace (State or Foreign Country)
D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	1 1929	Washington D
h with the	ai Director	10e. Street and Number 10f. Zip Code 12646 Catalina Drive 20657	10g. Citizen of United	What Country?
	d by Funerai	3 Widowed 4 Divorced Year or Dates: 16 40	or No- .) 14. Ra Bla Specia	ce - American Indian, ack, White, etc.
ING 21215-0036 be filed within 72 hours after tal Hygiene. d other than "natural, or lie event, Ina Madical Essanina	Completed		laundry	susiness/Industry  / vending
VI a	To Be	Dorothy Viol	ett	
or Healt litem 2		19a. Informant's Name/Relationship (Type, Print)  Florence Violett- wife  20a. Method of Disposition  1	D 20657 20c. Location	- City or Town, State
Baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or othe		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Funeral H	ria Virginia
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ry arrest,	C MD 20676 Approximate Interval Between Opset and Death
box bb/bb, death certificate be executed e attending physician and dor use as the burial-transit	dicai Examiner	d		10 113
the death certifing the attending ached for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1		te of delivery nnth Day Year
ecords, P.O. law requires that the data been signed by the	ompleted by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Yes 2 No	ribute to the cause of death?  3 Probably 4 Unknown
The lay	е Сотр	1 Ve	utopsy erformed? es 20 No	Were autopsy findings available prior to completion of cause of death? I ☐ Yes 2 ☐ No
on or ding Phy After this funeral d	ation; To B	examiner?  1   Yes 2   No		
UNISION Ital or Attending rs after death. ral Director: Afte	Certification:		Town, State)	er or Rural Route Number,
DIVISION To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Medicai		ne, date and place,	and due to the cause(s)
T with		pm. pull 046314	1	d (Month, Day, Year)
19+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr Ponto Prince Frederick (10078)  31. Date filed (Month, Day, Year)  15 2004		
St Regist	ate trar	31. Date filed (Month, Day Year) 1 5 2004 Market Ma		

State of Maryland / Department of Health and Mental Hygiene 38242 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Nov 20, 2004 Angeline Wagoner 7:20 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death **Devlin Manor Nursing Home** Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb 25, Birthplace (State or Foreign Country) **Funeral** 1□ M 2√ F 215-12-2256 Yrs. Director 82 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Exacitors must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany MD Cumberland Director 1. Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10301 Christie Road NE 21502 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aid Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hetrick L. Hiner Mary E. Pittman Hiner 19a. Informant's Name/Relationship (*Type, Print*)
William Wagoner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 86 Box 12 A Springfield WV 26 son WV 26763 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Ashby Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11/24/2004 Fort Ashby 4 ☐ Donation 5 ☐ Other (Specify) WV 21. Signature of Funeral Service Licensee 22. Namscarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause of each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 2 dry Examiner Examiner buriel-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ettending physician and I for use as the buriel-trer Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificete funeral director, pag 1 ☐ Yes 2E No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 

Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours efter death

To the Funeral Director: A

completely filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0017565 Jun 21, 2004 77 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LLUZIC 62 7 AJ Bellino NITI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 16 Rev 6/95

			For State Registrar	State	of Maryla	•	artment of H		, ,	iene	004	38243
			Decedent's Name (First, Middle	, Last)					2. Date of Deat	h		3. Time of Death
	Physicia /Medic		Regina	т.	Wil	lk			Novembe			10:40 Р м
	Examin	er	4a. Facility Name (If not institution	, give street and i	number)		4b. City, Town, or	Location of Death	1	4c. Co	unty of Death	
			17631 Goose C				Olney				ntgomer	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year)	9. Birthi	olace (State or Foreign ntry)
ш	Director		096-14-0615			81 Yrs.			July 25		3 New	York
	pc ,		Usual Residence of Decedent		100 (	City Town and a					· ·	Od Incide City Limite
	rylar		10a. State 10b. County		106. 0	City, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	e Ma	cto	Maryland Monte	gomery		Olne	У					1 163 2 2 140
	th th	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen	of What Cou	ntry?
	th wi		17631 Goose Cr	eek Road	1		20832			U:	SA	
	dea	Funeral	11. Marital Status		ecedent Ever in Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-		Race - Ameri Black, White,	
9	after or Ite	Fu	1 Never Married 2 Marri		s 2 X No		1 ☐ Yes 2 ፟ No	Specify:	0.1.100.1, 0.0.7		ecity: Whit	
8	hours after death with the Maryland turet', or ttems 23a or 28e-f show at Evanither must be notified at	l by	3 X Widowed 4 ☐ Divorced		Dates:		103 22110	opoony.		30	ocily. WILL	
2-0	72 hc	Completed	15. Decedent (Specify only highes		d)	16a. Dece	dent's Usual Occupa	ation during most of wor	rkina	16b. Kind	of Business/In	dustry
2	within 72 ene. then "nef	gle	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired	)	3			
2	d wit	OIL	12			Hor	nemaker			Own	Home	
ğ	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other then "neturel", or Items 23a or 28e-f show or other then "neturel", or Items 23a or 28e-f showevent, Item Medical Evandarian must be notified at	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's Nan	ne (First, Middle, I	Aaiden Sui	mame)	
a	should be nd Mental marked o	ToE	Anthony Rajcz	ewski				Tekla	Majka			
Maryland 21215-0036	sho sand l		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Street a	and Number or Ru	ıral Route Number	City or To	wn, State, Zip	Code)
	alth a		Damian A. Wilk/	Son		1362	Windmill	Lane, S:	ilver Sp	ing.	MD 209	905
ē	s 1 s f He item othe		20a. Method of Disposition			. Place of Dispo	sition (Name of matory or other place	ا	Date		ion - City or T	
Ë	ent o		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		m State	Gate	f Heaven	Mover	mber 19 004 S	ilver	Sorin	g. Maryland
Baltimore,	artm orter inju		21. Signature of Funeral Service				2. Name and Address				-	g, raryrana
B	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other treumetic enonge.	X 7	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	$\mathcal{L}($	el.							, MD 20901
			23a. Part1. Enter the disease, or	complications the	at caused the de							Approximate Interval Between
	ASSESSED.		shock, or heart failure. List Immediate Cause (Final	V								Onset and Death
7	Pnysician /Medical	r i	disease or condition resulting in death)	a.	coke to (or as a cons	courses off:					-	10 Years
	Examiner			Due	to (or as a corrs	equence or,						
Ŀ		-	Sequentially list conditions, if any, leading to immediate	b. Due	to (or as a cons	equence of):					-	
	ted	듣	if any, leading to immediate cause. Enter Underlying Cause (Disease of might)	<								
	xecu and	Examiner	that initiated events resulting in death) Last	c. Due	to (or as a cons	equence of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	a										
687	icate phys s the	edical		0								
	leath certific attending p I for use as	/Me	IF FEMALE:	23c. If yes,	outcome of preg	nancy				23d	. Date of deliv	erv
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?		e birth 2 □ Fe egnant at time o		□Ectopic pregnancy □ Other (s <i>pecify</i> )				Month	Day Year
o.	he de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		known							
α.	that the de led by the a detached	H.	Part II. Other significant condition	ons contributing to	death but not r	esulting in the u	inderlying cause give	en in Part I.	23e. Did to	acco use	contribute to t	he cause of death?
Vital Records,	sign sign d be	ompleted by	Seizure Disord	ler, Inti	apulmor	nary Noo	dules		1 🗆 Y	s 2 🛣	lo 3 🗆 Prol	bably 4 Unknown
or	w requir been si should	etec						A	04- 146		41- 141 1	Coding and the second series
ec	e law has t	du							24a. Was a autops perfori	v i	prior to co death?	opsy findings available empletion of cause of
E		So							1 ☐ Yes		1 Tes	2 No
/ita	Physicien: The I this certificate har ral director, page	Be	25. Was case referred to medica examiner?	-			O#5		ath (Check only or			-
of		2	1 ☐ Yes 2 ☑ No			☐ ER/Outpatie			lome 5 Reside			fy)
ם	ng P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	/4	ite of Injury fonth, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe ho	w injury o	ccurred	
010	Attending or death.	atl	2 Accident investi	gation			M 1 🗆	Yes 2 □No				
Division	r Att ter de irect	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined   288. Pi	ace of Injury - At iilding, etc. <i>(Spe</i>		reet, factory, office		28f. Location (Si City or Town		umber or Run	al Route Number,
	itel c irs af rel D											
	Hosp 14 hou Fune fely fil	edical	(Check only 2 Medical	Examiner: On the	e basis of exami		h occurred at the tin vestigation, in my o					
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Med	one) 29b. Signature and title of certifie		anner stated.		29c. Licens	e number	2	9d. Date s	igned (Month,	Day, Year)
1	F × F 8		1	R	1 9	,	D	4595				, 15, 2004
	IV		lawn	Bros	num		$\nu$	73 13	6	יעטן	mbu	,,,,,,,,,,
			30. Name and address of person  Dawn Asano Br				Print) Prince Ph	ilip Dri	ve, #275.	Olne	ey, MD	20832
	Sta	ate	31. Date filed (Month, Day, Year)		Registrar's Sig						·	
	Regist	rar	1×V 4 10	CUU4		10	Sparks					

			1 - For State Registrar	ate of Maryland	/ Depa	artment of H Tificate of L	ealth and M Death	lental Hygie Reg.	2004	38244
0	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Helen V. Wei					November	13, 2004	l
7	Examin	er	4a. Facility Name (If not institution, give street  Montgomery Hospice	e-Casev Hous	0		Location of Death		4c. County of Deat	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	Rockvil If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgome 9. Birt	holace /State or Foreign
	Director		579-42-4934 1□M	2 <b>K</b> F 8	8 Yrs.	Months Days	Hours Min.	(Month, Day, Ye Feb. 28,	1916 Wes	t Virginia
	pug *		Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Lo	cation				10d. Inside City Limits
	the Marylar 28e-f show	ō								1 ☐ Yes 2 ☑ No
	r 28e-	Director	Maryland Montgomer  10e. Street and Number	У БІІ	ver S	10f. Zip Code		10g.	Citizen of What Co	untry?
	th with	al D	3632 Gleneagles Dri	ve, Bldg. 8	. Ant	1 G	20906		USA	
	ems erm	Funeral	11. Marital Status 12. V	as Decedent Ever in U.S	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	s afte	by Fu	If	☐ Yes 2 <b>/CXN</b> o Yes, Give ear or Dates:		I ☐ Yes <b>※</b> IXNo	Specify:		Specify: Wh	
21215-0036	within 72 hours after death with the Maryland ane. then "neturel", or Items 23s or 28e-1 show to Nedical Evar thermillad at	edk	15. Decedent's Education		16a, Deced	ient's Usual Occupa	ation	166	. Kind of Business/	
215	hin 72 e. en "ne	Completed	(Specify only highest grade con	ollege (1-4or 5+)	(Give	kind of work done of OO NOT use retired,	lurina most of worki	ng		,
	ygiene ygiene er th	Con		4	Nu	rse			Medical	
Maryland	be fill Hall H	Be	17. Father's Name (First, Middle, Last)			The second secon		(First, Middle, Mai	den Sumame)	
Z,	thould d Mei mark metic	은	Max Hall  19a. Informant's Name/Relationship (Type, F	rint)	19b. Mailin	n Address (Street a		Simpson  I Route Number, C.	tv or Town State 2	7in Code)
	nd 2 s lith an 27 is r treu		Francis Yeatman/Atto					, Betheso	•	
Je,	item of head		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of			. Location - City or	
Ë	Page ment ent: If ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remore 4 ☐ Donation 5 ☐ Other (Specify)	val from State M	etropo Crei	natory`or other place Dlitan natory		0.4	.exandria	, Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23s or 28e-1 show empirity or other treumetic event, its Medical End. It without be indifficed and		21. Signature of Funeral Service Licensee	a long	22 F1 50	Name and Addres rancis J. 00 Univer	s of Facility Collins sity Blvd	Funeral H	lome Inc er Spring	g, MD 20901
П		9	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ns that caused the death. use on each line.	Do not ente	er the mode of dying	g, such as cardiac c	r respiratory arrest,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	End-Stage C		nyopathy		<u> </u>		Onset and Death
1	/Medical Examiner		roccining in dealiny	Due to (or as a conseque			cı '			
	•	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Severe Aor  Due to (or as a conseque		cenosis,	Chronic			
	cuped nd transit	Examiner	that initiated events							
60,	cate be executed physician and the burial-transit	J EX	resulting in death) Last	Due to (or as a conseque	nce of):					
58760,		edical	d							
Box (	death certific e attending p od for use as	n/Me		yes, outcome of pregnan		10.			23d. Date of deli	very
	0 0 5	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	□Live birth 2 □ Fetal o □Pregnant at time of dea □ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	d by the	Phy	9 ☐ Unknown  Part II. Other significant conditions contribu		ing in the cu	-deal in	in Don't	220 Did tobac	a usa seetabuta ta	the cause of death?
Records,	es on be	by	Part II. Other significant conditions continue	ting to death but not result	ing in the di	idenying cause give	m m Part I.			obably 4 Unknown
COL	> 40 00	Completed						24a. Was an	24b. Were au	topsy findings available
Re	ysicien: The lav is certificate has director, page 2	omp						autopsy performed 1 ☐ Yes 2 🔀	? prior to death?	completion of cause of
Vital	ien: rtifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Death		140 103	20110
of <	Physicien: this certific ral director,	ဥ	1 ☐ Yes 2 🗵 No	1   Inpatient 2   E	R/Outpatien		4   Nursing Hor			eify) Hospice
on o	fter	ion:		a. Date of Injury (Month, Day Year)	8b. Time of Injury	Work	at ? ′es 2 □No	28d. Describe how i	njury occurred	Facility
Division	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be	e. Place of Injury - At hom	ie, farm, str			28f. Location (Street	and Number or Ru	ral Route Number.
οį	after I Dire	Certification:	4 Homicide determined	building, etc. (Specify)	,,	,,		City or Town, S	tate)	•
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (	(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examination and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of centifier			29c. License	number	29d.	Date signed (Month	i, Day, Year)
	12		CECTI			D4	1212		1/13/0	94
_			30. Name and address of person who comple Charles Harrison, M	D 6001 M	masat		Road, Roc	kville,MD	20855	1
	Sta Regist		31. Date filed (Month, Day, Year) <b>NOV 16</b> 2004	32 Registrar's Signatu	B,	Sports				

			1 - For State Registrar	State of	Marylar		artment of rtificate of				giene Reg. Nd	21101.	38	245
	Physici /Medi		Decedent's Name (First, Middle,     KATHERIN	•	ARD					2. Date of De Month NOVEMBI	ath Da		3. Time	of Death
	Examir		4a. Facility Name (If not institution,	give street and num	ber)		4b. City, Town,	or Locatio		IVO VELIBI		. County of Dea		02 1
			MONTGOMERY GENE				OLN				]	MONTGOM	ERY	
	Funeral Director		214-48-6684	Sex 1 M 2 F	'. Age (In yrs. 47	/ast birthday) Yrs.	If Under 1 Yea Months Days		der 24 Hrs. s Min.	8. Date of Bird (Month, Da MAY 30	h y, Year) 19	9. Bi	rthplace (State ountry) SHINGTO	e or Foreign N
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside	City Limits
	Mary 9-f sh	tor	MARYLAND MONTG	OMERY		ROCKV	LLE							s 2 No
	or 28	Direc	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What C		
	s 23a	ral	15404 CARROLTON				20	853			UNI	TED STA	TES	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show my injury or other treumatic event, the Medical Examinar must be notified at once.	by Fune	11. Marital Status  1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 1 Yes 2 If Yes, Give Year or Dai	es? MNo	'	Was Decedent of f Yes, specify Cu ☐ Yes 2X No	ban, Mexic	can, Puerto I	cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi	erican Indian, te, etc. HITE	
5-0	72 ho	eted	15. Decedent's (Specify only highest	Education		16a. Deced	lent's Usual Occu	pation	nost of working	20	16b. Ki	ind of Business		
12	within ne. han "	mpl	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of work done OO NOT use retin			ig .				
р В	filed v Hygie ther t	Co	17. Father's Name (First, Middle, La	3 (st)		CLI	ERICAL T	1		(First, Middle,	Maidan	BANKIN	G	· · · · · · · · · · · · · · · · · · ·
<u>a</u>	ld be ental ked o	o Be	RONALD A. WARI	,					IARRIE'	_	ARTI	,		
Maryland	and M s mar	-	19a. Informant's Name/Relationship			19b. Mailin	g Address (Stree						Zip Code)	
Σ,	and 2 salth a n 27 i		RONALD A. WARD,	FATHER			CARROL'						853	
altimore,	- Se H		20a. Method of Disposition 1 Derial 2 Cremation 3	X PRemoval from Si		Place of Dispo- emetery, cren	sition (Name of natory or other pla	sce)	D	ate	20c. Lo	ocation - City or	Town, State	
Ē	t. Pa	0	*4 ☐ Donation 5 ☐ Other (Spe	cify)			CREMATO		11/1			S CHUR	CH, VA	
Ba	Depa Impo any ii		21. Signal are of Juneral Service Lic	2. Jun		10	WARD SA	VILLLE	PIKE	, KOCKV	$T \Gamma \Gamma \Gamma \Gamma$	I, INC.	20852	
	Physician		23a. Part Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition	emplications that can be one cause on each	used the death th line.	Do not ente	or the mode of dy	STEA	as cardiac or	respiratory and	rest,		Approxima Interval Be Onset and	etween
	/Medical Examiner		resulting in death)	Due to (o.	r as a consequ	uence of):				-				
		er	Sequentially list conditions,	b. Due to (o	ras a consequ	Halida ori								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
Ö,	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or	as a consequ	uence of):								
68760	the bu	edical		d										
ox e			IF FEMALE:	23c. If yes, outco	me of pregna	nev	-				-1-			
о В	0 0 0	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐ Live birt	h 2∏Fetal nt at time of de	death 3 🗌	Ectopic pregnand Other (specify)	y 			2	23d. Date of del Month	,	Year
S,	as the	by P	Part II. Other significant conditions	contributing to dea	th but not resu	ulting in the un	derlying cause gr	ven in Pari	t I.	23e. Did to	bacco u	se contribute to	the cause of	death?
ecords,	w require been signal								<del></del>	1 🗆 Yı	es 2[	□No 3□Pr	obably 4 🖪	Unknown
r	The ate ha	Completed								24a. Was a autops perform	sy	prior to death?	topsy findings completion of a	available cause of
<b> </b>		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:			Otto	ner		(Check only on				
	g Phys er this eral di	-	27. Manner of Death	28a. Date of	Injury	ER/Outpatient 28b. Time of	28c. Inju	4 ∐ N ryat		e 5 □ Reside 3d. Describe ho		Other (Spec	cify)	
0	Attending I r death. ector: After by the funer	atlo	1 ♣Natural 5 Pending 2 Accident investigat	on	Day Year)	Injury	Wo M 1□	rk? ∣Yes 2.[	_					
DIVISION	ne Hospitel or Attend 124 hours after death 16 Funerel Director: A bletely filled in by the f	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of	Injury - At ho	me, farm, stre	et, factory, office		28	3f. Location (St City or Town	reet and n, State)	l Number or Ru	ral Route Nun	nber,
	To the Hospitel or a within 24 hours after To the Funerel Direct completely filled in the formulation of the	edical	29a. Certifier (Check only one) 1 Certifying I 2 Medical Ex	Physician: To the beaminer: On the basi and manner	s of examinati	wledge, death ion and/or inve	occurred at the tilestigation, in my o	me, date a ppinion, de	and place, ar eath occurred	nd due to the ca d at the time, d	ause(s) a ate and	and manner as place, and due	stated. to the cause(s	s)
	To the To the complet	X	29b. Signature and title of centifier	*			29c. Licens	e number	,	2	9d. Date	signed (Montl	, Day, Year)	
	0		- Thun	2/2			D	26	2 +1		[1]	13/0	4	
	•		30. Name and address of person who	o opripleted cause		23a) (Type, P	ERNWO	an a	20	SETIF	SDA	OM,	204	17
	Sta	e.	31. Date filed (Month, Day, Year)		istrar's Signat		44000		,	1110		11.11.	- 00	. A
6	Registra	-	NOV 16 20	na Z	war	29	Aparka.	/						

			1 - For State Registrer	te of Maryland / Do	epartment of Health and Certificate of Death	Mental Hygie	ene2004	38246
15	Physic		1. Decedent's Name (First, Middle, Last)  David J. Wakefield			2. Date of Death Month	Day Year 12 2004	3. Time of Death
	/Medi Examii		4a. Fecility Name (If not institution, give street a Laurel Regional Hospi  5. Social Security Number 6. Sex	tal	4b. City, Town, or Location of De  Laure1  day/ If Under 1 Year   If Under 24 H	path	4c. County of Deeth	orges
L	Funeral Director		213-40-8514 1⊠ M 20 Usual Residence of Decedent	65	s. Months Days Hours M		939 Wash:	place (State or Foreign ntry) ington DC
	the Marylan r 28a-1 show	rector	MD         Montgomery           10e. Street and Number	10c. City, Town o	Silver Spring	100	. Citizen of What Cou	10d. Inside City Limits 1 X Yes 2 No
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or ttems 23a or 28a-f show event, the Madical Evartiner must be rotified at	by Funeral Director	1 Never Married 2 Married 1 W		20904  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu  1 Yes 2 No Specify:	U	nited Stat	can Indian,
Baltimore, Maryland 21215-0036	led within 72 ho lygiene her than "naturi it, ina Medical i	Completed		ege (1-4or 5+)	ecedent's Usual Occupation Sive kind of work done during most of v fe. DO NOT use retired)  vil Engineer	vorking	b. Kind of Business/In	
ryland	⊕ = = ≥	To Be	17. Father's Name (First, Middle, Last)  Benjamin Wakefield  19a. Informant's Name/Relationship (Type, Prir	196 A		ne A. Munro		- 0-41
re, Ma	and 2:		Karen Wakefield/ Siste	er 206. Place of D	41 Miracle Drive,	Gaithersbu	rg, MD 208	82
Baltimo	permit. Pages 1 Department of H Important: If its any injury or ot		1 Burial 2X Cremation 3 Removal 4 Donation 5 Other (Specify) 21. Signature of Funeral Services Licensee	Metropo	litan Crematory  22. Name and Address of Facility I	Zember 2004 Ale DeVol Funera	al Home. 1	0 East
7	Physician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not e on each line. Acute Myoca:	rdial Infarction			Approximate Interval Between Onset and Death Minutes
8760,	death certificate be executed xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	dical Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of).				
.O. Box 6	death certifi e attending ad for use as	hysician/Med	in the past 12 months?	s, outcome of pregnancy Live birth 2 Petal death Pregnant at time of death Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive	ery Day Year
σ.	w requires that the been signed by the should be detached	by P	Part II. Other significant conditions contributing Stage IV Bronchogeni	g to death but not resulting in th C Carcinoma	e underlying cause given in Part I.	23e. Did tobaco	co use contribute to th	ne cause of death?
Vital Records	The la ate has page 2	Completed				24a. Was an autopsy performed 1 Yes 2 X	? prior to cor death?	psy findings available inpletion of cause of
of	To the Hospital or Attending Physician: whim 24 hours after death as the team. To the Funatal Director. After this certific completely filled in by the funeral director,	ation: To Be	1 Natural 5 Pending 2 Accident investigation	1 ☑ Inpatient 2 ☐ ER/Outpa Date of Injury (Month, Day Year) 28b. Tim Inju	tient 3 DOA Other: 4 Nursing	eath (Check only one)  Home 5 Residence 28d. Describe how in		()
Division	vital or Atto ars after de ral Diracto	Certification:	4   Homicide	Place of Injury - At home, farm, building, etc. (Specify)		City or Town, St		
	To the Hospital or within 24 hours after To the Funaral Dir. completely filled in it.	Medicai	one) 2 Medical Exeminer: On and	o the best of my knowledge, de the basis of examination and/o manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occ	curred at the time, date	and place, and due to	the cause(s)
ŧ	1K.0	-	29b. Signature and title of certifier  30. Name and address of person who completed	Vanen, H	29 License number UN 29 License number		November 1	
	Sta	te	William A. Warren M.I		George Street, La	urel, MD 20	707-4338	
	Registr	7	NOV 16 2004	Denever B	sporker			

			1 - For State Registrar	State of	Marylan	nd / Depa <i>Cel</i>	artment <i>rtificate</i>	of He	ealth and eath	Mental H	ygien Reg. N	2004	38247
	Dhuaiai		1. Decedent's Name (First, Middle, L	ast)			-			2. Date of D	eath Da	ay Year	3. Time of Death
	Physici /Medio		Carlos Anzoa	ategui						I -		004	4:48 a M
	Examir	ner	4a. Facility Name (If not institution, ga		ber)		4b. City, T	Town, or L	ocation of De	ath	40	. County of Death	1
			Holy Cross Hospi  5. Social Security Number 6.		. Age (in yrs.	In at high day.	Si.	lver	Spring		11-41-	Montgor	nery
	Funeral Director		570-38 <b>-</b> 0876	1 □XM 2 □ F	73	Yrs.	Months	Days	Hours M	n. (Month, L	Jay, Year	) Col	place (State or Foreign intry)
-	ס		Usual Residence of Decedent							0ct. 2	1 و / 2	931 N	caragua
	urylan show		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Sa-f s	Sch		gomery		Poo	lesvi	l1e					1 Tyes 2 No
	with th	Die	10e. Street and Number				10f. Zip (	Code				tizen of What Cou	
	s 23g	erai	17413 Collier Wa	y 12. Was Dece	toot Supris II	C 10		208		/O		nited St	
	ter d	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Ford	ces?	.5.	rvas Decede If Yes, speci	fy Cuban,	Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	10-	<ol> <li>Race - Amer Black, White</li> </ol>	
9	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at	P	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da			X Yes 2					Specify:	white
5-0	72 ho	Completed	15. Decedent's E (Specify only highest of			16a. Dece	dent's Usual	Occupati	caragion on ring most of w		16b. F	(ind of Business/I	ndustry
7	- 3	npie	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use	e retired)		orking			
121	filed within Hygiene. other than rent, the M		12 17. Father's Name (First, Middle, Las	41			Night					Hospital	ity
Maryland 21215-0036	9 15	Be c	_	1)				1		ame (First, Midd)			
2	should be ind Mental I	ဥ	Carlos Anzoate 19a. Informant's Name/Relationship	_		19h Mailir	na Address	Street an		ranza A		itegui or Town, State, Zi	n Codel
	nd 2 s		Dorine Anzoates							oolesvil			
altimore,	es 1 and 2 should b of Health and Ment fitem 27 is marked r other treumatic e	1	20a. Method of Disposition			Place of Dispo emetery, cren	sition (Name	e of	way, I	Date		ocation - City or T	
Ë	Page net o nt: If		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation / )5 ☐ Other (Spec	□Removal from S fy)	tate Che	esapeal	ke Cre	emato	ry  12	/4/04	В	eltsvill	e, MD
Balti	permit. Pages 1 Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service Lice	John Coll	Pana	/ Ra	Name and	inera	1 and	Crematio	n So	rvices	
	2	$\vdash$	23a Part I. Enter the disease, or cor	plications that ca	used the deat	- 19	3.3 GLS	t Av	enue S	ilver Sp	xina	, MD 20	910 Approximate
	Physician	Ì	Immediate Cause (Final	one cause on ea	ch line.					•			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	- M	ertensi rasa conseq						-		
	Examiner		Conventially list conditions	b Live	er Cano	cer							
	p .≒	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Under ving	Due to (o	r as a conseq	uence of):							
	ecute and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (e	r as a conseq								
8760,	icate be executed physician and s the burial-transit	a E		505 10 (5	i as a consequ	derice or).							
	phys phys s the	dical		_ d.									
Box (	law requires that the death certific as been signed by the attending p .2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23d. Date of deliv	erv
Ď.	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	th 2□Fetal nt at time of d		Ectopic pre Other (s <i>pe</i>					Month	Day Year
P.O.	that the de led by the a detached t	hys	9 Unknown	9□ Unknov	vn								
ŝ	es tha igned be de	by F	Part II. Other significant conditions	contributing to dea	th but not resi	ulting in the ur	nderlying car	use given	in Part I.	23e. Did	tobacco	use contribute to t	he cause of death?
ord	v requir been s should		Hepatitus B							1 🗆	Yes 2	□No 3□Prol	bably 4 🛣 Unknown
Records,	has be	Completed	Alcoholism							24a. Was	psv	prior to co	ppsy findings available impletion of cause of
_	The aste	Con								perf	ormed? 2. No	death?	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				2 Other:		eath (Check only			
ō		1: To	1 ☐ Yes 2√ No 27. Manner of Death	1 (3/10)	140	ER/Outpatien 28b. Time of		c. Injury at		Home 5 Res 28d. Describe		6 Other (Special	(y)
O	Attending I r death. ector: After by the funer	tion	1 Natural 5 ☐ Pending investigated	28a. Date of (Month)	Day Year)	Injury	м	Work?	s 2 □No	200. 00001100	11011 111101	iy occumed	
Division	I or Attendate death Director:	ifica	3 Suicide 6 Could not	28e. Place o	f Injury - At ho	ome, farm, stre	eet, factory,	office	_	28f. Location	(Street ar	nd Number or Rura	al Route Number,
ā	s afte	Certification:	4  Homicide	building	g, etc. (Specify	/)				City or To	wn, State	)	
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	edical (	29a. Certifier 1 XCertifying P (Check only one) 2 Medical Exa	hysician: To the b miner: On the bas and manne	is of examinat	wledge, death tion and/or inv	occurred at restigation, i	the time, n my opin	date and plac ion, death occ	e, and due to the curred at the time	cause(s) , date and	and manner as s place, and due to	tated. o the cause(s)
	To th within To th compl	Me	29b. Signature and title of contifien	On.	1	. 2-	29c.	License n	umber		29d. Da	te signed (Month,	Day, Year)
i.	1.1		11/11/1	The said	lome	1/1/		D2	6057			December	2, 2004
	VOX.		30. Name and addr = s of person who	completed cause	of death (Item	23a) (Type,	Print)						_,,
	't		Dr. David I		12012		s Mill	Roa	d, Whe	aton, MD	20	851	
	Sta Registr		31. Date filed (Month, Day, Year)  FC 0 3 2	004 A2. Reg	istrar's Signa		So	reks	/				

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of	Health and r <i>Death</i>			38248
	Physici	an	Decedent's Name (First, Middle, L.)	ast)			2001.7	2. Date of Death		3. Time of Death
	/Media	al	HOWARD WALLAC					November	r 25 200	
	Examir	er	4a. Facility Name (If not institution, g	ve street and number)		4b. City, Town,	or Location of Death	1	4c. County of De	ath
	Funeral		5. Social Security Number 6.		je (In yrs. last birthda)			8. Date of Birth	N/A 9. B	irthplace (State or Foreign
	Director		216-62-1813	1 🛣M 2 🗆 F	51 Yrs.	Months Days	Hours Min.	(Month, Day, Feb 19		irthplace (State or Foreign Country) IARYLAND
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Mary Fish	ţō	MARYLAND N/A		DAT	TIMORE				1 ⊠Yes 2 □ No
	th the or 288	Director	10e. Street and Number		DAI	10f. Zip Code		10	g. Citizen of What C	Country?
	ath wi		831 STAMFORD			2	1229		U.S.A.	
	ter de Items	Funerai	11. Marital Status 1 □ Never Married 2 X Married	12. Was Decedent Amed Forces? 1 XYes 2		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp ean, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh	erican Indian, ite, etc.
980	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: BI	ACK
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other then "netural", or items 23a or 28a-f show ant, the Medical Evantiner must be modified at	Completed	15. Decedent's I (Specify only highest g	ducation	16a. Dec	edent's Usual Occup	pation	kina 1	6b. Kind of Busines	
12	within sne. than "	mpi	Elementary/Secondary (0-12)	College (1-4or 5	0+)		during most of work d)	Wing		
0	filed y Hygie other ant, L		12th grade  17. Father's Name (First, Middle, Las		EMPLO	YMENT SPI		ie (First, Middle, M	MAXIMUS	
<u>la</u> n	lid be fental rkad c	To Be	HOWARD ANDERSO	N SR				A V BOSTO		
Maryland	and Nama		19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ing Address (Street	and Number or Rur	ral Route Number,	City or Town, State,	Zip Code)
Z G	and and m 27 m 27 her tr		Corrine Anderso	n/Wife					Maryland	21229
Jore	iges 1 tof H : If ita		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 l		20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	сө)	Date 2	0c. Location - City o	r Town, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be redified at once.	1	<ul><li>4 □ Donation 5 □ Other (Spec</li><li>21. Signat e of Funeral Service Lice</li></ul>		GARRISON	FOREST  2. Name and Addre		02-04 0	WINGS MIL	LS, MARYLAND
Ba	Depa Impo any is		Salara (	1.1	W 1	ILLIAM C 206 W NOF	BROWN COM TH AVENUE	2	UNERAL HO	ME P.A.
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the cause on each lin	10.	17.7		or respiratory arres	st,	Approximate Interval Between
S	Fnysician /Medical	4	Immediate Cause (Final disease or condition resulting in death)	product of the best of the second	ranial 1	emorrh	age			Onset and Death
	Examiner		ſ	Due to (or as	a consequence of):	emorrh yperkn	01.020			1 month
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	Therrow	310/1			[ 11,010,771
11/2	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (ex a						
68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	ai		Due to (or as	a consequence of):					
89	tificate ig phy as the	ledicai		_ a						
Вох	ath cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome		□Ectopic pregnancy	,		23d. Date of de	livery
0	The law requires that the death cer te has been signed by the attendir oage 2 should be detached for use	Physician/IV	1 Yes 2 No	4□Pregnant at 9□Unknown		Other (specify)		-	Month	Day Year
J.	res that tigned by	y Ph	Part II. Other significant conditions	contributing to death be	ut not resulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	w requires been sign should be	Completed by	Morbid obesitu					1 ☐ Yes	2 No 3 □ P	robabły 4 🗆 Unknown
ဝင္	has bei	piet	<u> </u>			_		24a. Was an	24b. Were a	utopsy findings available
		Соп						autopsy performe	d2 death? No 1 ☐ Yes	completion of cause of
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		oth Oth		(Check only one)	7,500	
ō	y Physics ar this eral di	P= 1	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur	v 28h Time c	f 28c. Injur	y at	me 5 🗌 Resident 28d. Describe how	ce 6 Other (Spe	cify)
0	anding bath. or: Afte	atio	1 Natural 5 Pending investigation		Year) Injury	M 1	k? Yes 2 □ No		, ,	
DIVISION	I or Attanding Phys after death. Diractor: After this I in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		rry - At home, farm, st :. (Specify)	reet, factory, office		28f. Location (Stree City or Town,	et and Number or Ri State)	ural Route Number,
	spital ours a laral E		29a. Certifier Certifying Pl	veicien: To the best of	if my knowledge, deat	b occurred as the size				
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	(Check only 2 Medical Exer	nysicien: To the best on niner: On the basis of and manner sta	examination and/or in	vestigation, in my o	pinion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the trouble comp	Ž	29b. Signature and title of certifier	14.0	n	29c. License		29d	. Date signed (Mont	h, Day, Year)
			Meleo	ons	IND		618	No	vember 2	5,2004
	lot		30. Name and address of person who Shiel Song M.	completed cause of de	eath (Item 23a) (Type, Cafon AVA	Print) Balti	more, m	D 2122	9	
	Stat Registra		31. Date filed (Month, Day Year) DEC 0 3 2	32. Sgistra	r's Signature	aut)	, , , , , , , , , , , , , , , , , , , ,		1	

AKG	303		1 - For Unpend Iter	n 23a,27,28a	r <del>y</del> land/Dep Ce	ettificate o	Bealth and f Death	g Mental Hy	giene () (	) l <sub>4</sub>	38249		
	<b>D</b> I -1-1		Decedent's Name (First, Middle, Last)					2. Date of De	2. Date of Death Month Day Year  3. Time of Death				
Physician /Medical			Tony Mormon Abbott, Jr.						November 29, 2004 6:15 A M				
Examiner		er	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death		
5			222 Old Riversic		(In yrs. last birthday	Brookly		Hrs. 8. Date of Bi		Arur			
1600	Funeral Director		219 82 6585	70	43 Yrs.	Months Day		May 16	1961	Counti	ginia (State or Foreign ginia		
	D		Usual Residence of Decedent					1 1 2 1 1	,				
	anylan show	-	Maryland Anne		10c. City, Town or L					10	d. Inside City Limits		
ဖ	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23e or 28a-1 show or other treumetic event, the Madical Examinational be notified at	ecto							· · · · · · · · · · · · · · · · · · ·		1 ☐ Yes 2X No		
		급	10e. Street and Number 222 Old Riverside Road 21225						10g. Citizen of V		r <b>y</b> ?		
		Funeral Director					Decedent of Hispanic Origin? (Specify Yes or Nos, specify Cuban, Mexican, Puerto Rican, etc.)			e - America	n Indian		
			Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No							Black, White, etc.			
03		d by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:						Specify: White				
5-0		Completed	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of work life. DO NOT use retired)						ing 16b. Kind of Business/Industry				
121		ш	Elementary/Secondary (0-12)  6th  College (1-4or 5+)  Carpenter						Construction				
d 2			17. Father's Name (First, Middle, L	.ast)		1	18. Mother's	Name (First, Middle					
Maryland 21215-0036		To Be	Tony M. Abbott Sr. Fa						e Jeanette Jones				
ary			19a. Informant's Name/Relationsh					r Rural Route Numb	er, City or Town,	State, Zip C	Code)		
	1 and 2 Health tem 27 I		Heather Abbott	t / wife		old Rive	rside Ro		klyn, Ma	rylan	d 21225		
altimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other p	lace)	Date	20c. Location -	City or Tow	n, State		
Ë			'4 Donation 5 Other (Specify) Bayview Crematory 12/2/2004 Baltimore, Maryland										
Bal	permit. Pa Departmer Importent any injury		21. Signature of Funeral Service L	1	/ -	2. Name and Add		Gonce Fur	eral Ser	vice,	P.A.		
			23a. Part 1. Enter the disease, or	Smolications that caused t	he death. Do not er	001 Ritc	nie High	IWay Bal	timore,		Land 21225 Approximate		
	Pnysician		23a. Part 1. Enter the disease, or simplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Narcotic and Hydroxycarbazepine intoxication										
	/Medical		disease or condition resulting in death)	a	consequence of):	Oxycar ba	ахертне .	IIICOXICAL	1011	-			
	Examiner		Sequentially list conditions	b									
	ק ק	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events		consequence of):								
	ecute and trans	Examiner	that initiated events resulting in death) Last	C	consequence of):								
8760,	cate be executed physician and the burial-transit				consequence on,								
687	ficate physics the l	edlcal		d			·· <del>·</del> ·································			-			
Вох	certific inding p	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		7			23d. Date	e of delivery	,		
	that the death certificed by the attending I detached for use as	Physician/Me	in the past 12 months?  1						Mor	Month Day Year			
P.0	that the ed by th detache	Phys	9 Dunknown										
	Se Le	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?				
orc	w requires been sign should be	eted						-   '-	Yes 2 □ No	3 Probat	oly 4 Nnknown		
of Vital Records,	e las has	Completed						24a. Was	<b>psy</b> p	Vere autops rior to com: leath?	y findings available pletion of cause of		
a	Thate ate		OS Man and advantage madical					1 Yes	2□ No 1		□ No		
ξ	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1    Yes 2   No	Hospital: 1 ☐ Inpatien	2 DER/Outpatie	nt 3□ DOA	Nh an	Death (Check only of		or (Canaily)	at scope		
o	g Phys er this eral di	H	27. Manner of Death 28a Date of Injury 28b Time of 28c Injury at 28d Describe how injury occurred 110K										
0	Attending I r death. ector: After by the funer	atlo	1 Natural 5 Pending Found, Day Year) Found, Found, Month, Day Year) Found, Month, Day Year) 1 Yes 2X No										
Division	or Atto	Certification:	3 ☐ Suicide  4 ☐ Homicide  SX Could not be determined  28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State) Found 222 01d							Route Number,			
۵	urs at		round in residence Riverside Rd., Brooklyn, MD										
	Hosi 24 ho Fune stely f	edical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☑ Medical E	Physician: To the best of xaminer: On the basis of and manner state	examination and/or in	th occurred at the exestigation, in my	time, date and play opinion, death of	ace, and due to the ccurred at the time,	cause(s) and mar date and place, a	nner as stat ind due to tl	ed. ne cause(s)		
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Med	29b. Signature and title of certifier	and manner state		29c. Lices	nse number		29d. Date signed	(Month, Da	ay, Year)		
	Pi,		De Carre	HALDON W	id	o.c.	M.E.		November	r 29,	2004		
11	reduig		30. Name and address of person v	who completed cause of dea	ath (Item 23a) (Type	Print)							
, <u> </u>	Sr.		CAROLHAU	LANMA		111 Pen	n Street	, Baltimo	ore, Mary	yland	21201		
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 3 200	32. Registrar	-	1				-			
	riegisti	- C. ()	nro 0 9 (()(	14 Lines	19	Acres 1	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8609 Edward James\_ Akins II /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HKINER HEALTH OF B 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday ear Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ★M 2 ☐ F Director 83 214-18-3500 June 8, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show treumatic event, the Medical Examiner must be notified at 1 Ves 2 □ No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e 142 Alice Anne Street 21014 USA Funerai Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 X Divorced Black "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Cook Restaurant and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ James Edward Akins, Sr. Mary (unk) Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is eny injury or other tre once. Dorothy M. Presberry / Daughter 18 Shannon Drive, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Tabernacle U.M. Cem. | 12-3-04 Fallston, Maryland 21. Simply of Fufferal Service Ligensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 50 W. Broadway St., Bel Air, Maryland 21014 Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician tastatic Works /Medical Due to (or as a consequence of): **Examiner** Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner to the Hospitel or Attending Physicien: The law requires that the death certificate be executed Faitur Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 70 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. in by the Director: 6 Could not be 3 Suicide

Box 68760, Division of Vital Records, P.O.

Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Jun, M. K

uite 105;

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

32. Registrar's Signature 31. Date filed (Month, Day, Year)

within 24 hours a To the Funerel L

State of Maryland / Department of Health and Mental Hygiene 0 0 4 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Walter N. Asquith November 19, 5:30 PM M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 10, 1 5. Social Security Number Birthplace (State or Foreign Country)
 Unk **Funeral** 1⊠M 2□F 182-16-2995 82 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28e-f show the Medical Examinar must be notified at MD Harford 1 ☐ Yes 2 ☑ No Director Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 S. Market Street 21078 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married unk 1 ☐ Yes 2 No Specify: Specify: à white 3 X Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "na any injury or other treumatic event, the Media. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harford Memorial Hospital 501 S. Union Avenue Havre de Grace, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 ☒Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature of Funeral Societa Licensee Ronald Wade Baltimore, MD 21201

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 20 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed isch lunc Card Dung patter 24b. Were autopsy findings available pror to completion of cause of death? autopsy performed? 1 Yes 25. Was cas examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 1944 hours after death. 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 38252 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 1519 anie Dec 04 /Medical D 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death hesaDeak e Har Ford If Under 24 Hrs. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) July 26 1930 **Funeral**  Birthplace (State or Foreign Country) 19M 20F Months 216-24-9866 Days Hours Min. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location itam 27 is markad other than "natural", or items 23a or 28a-1 show other traumatic avant, the Medical Examinations the prolified at 10d. Inside City Limits Director 1 HYes 2 No Edgewoo Hot. Zip Code 10e. Street and Number 10g. Citizen of What Country? Was Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Dres 2 No Amy 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1953-955 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If itam 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) ithographer 19 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgewood 708 MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date , 20c. Location - City or Town, State 1 □ Burial 2 1 Cremation 3 □ Removal from State Metro ` 4 ☐ Donation 5 ☐ Other (Specify) Cramatory 13-7-04 21. Signature Ineral Service Licenses 22. Name and Address Facility 1232 Mid Valley Dr. Jessup, PA 18434 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or beart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician cest Cere mal Hemorrhage /Medical Due to (or as a consequence of) **Examiner** 6 hours. Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1□ Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending

Hospital or Attanding Physician: The law requires that the death certificate be executed Danie Medical Certification; To Bahur, death investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To tha Funarat Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) B. PAREKH MD. DO0 8424 De(-3-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1908 MD. Fallston B. Parekh Harford Road 31. Date filed (Month, Day, Year) 32. Regis ar's Signature State DEC 0 3 2004 Registrar

			1 - For State Registrar	State of Maryland / De	partment of Health and ertificate of Death		4004 38/5
	Physic	ian	1. Decedent's Name (First, Middle, Las			2. Date of Death	No. 3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give	atract and number)	DRITT	Month 12	2 84 7:45 AM
1	Exami	ner	Manaclare 1	Nood bridge Valley	4b. City, Town, or Location, of Dea	ath D	4c. County of Death
	Funeral Director		5. Social Security Number 6. Se	x 7. Age (In yrs. last birthda	Months Days Hours Mir		9. Birthplace (State or Foreign Country)
	ס		Usual Residence of Decedent  10a. State 10b. County	100 City Town		15-23-1	6 110
	Maryla 9-f sho	to	Mh Prime G	10c. City, Town or	Groonhott		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Director	10e. Street and Number	0	10f. Zip Code	10g.	Citizen of What Country?
	death v	Funeral	1505	12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - American Indian,
36	s after , or Ite	by Fui	1 Never Married 21 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ∰ No If Yes, Give	If Yes, specify Cuban, Mexican, Pue 1 Yes 2 No Specify:	rto Rican, etc.)	Black, White, etc.
21215-0036	72 hours atter death with the Maryland netural; or Items 23a or 28e-f show disal Examinar must be netified at	ted b	15. Decedent's Edu		cedent's Usual Occupation	16b	. Kind of Business/Industry
121	within ene.	Completed	(Specify only highest grad	Gollege (1-4or 5+)	ve kind of work done during most of wo DO NOT, use retired)	orking	11.
	be filed with stal Hygiene. od other than	Be Co	17. Father's Name (First, Middle, Last)	7 10.	UNUM UP.	me (First, Middle, Maid	UNUON den Sumame)
Maryland	should be and Mental is marked o	2	Universe Hiller 19a. Informant's Name/Relationship (Ty	Driet 101.11	Man	e Hill	
	£ 7 ₹		Warren R.B. Britt	(Son)   260	iling Address (Street and Number or F	ural Houte Number, Cit	y or Town, State, Zip Code)
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	emioval from State	ematory or other place)	Date 20c.	Localion - City or Town, State
altin	+ E E =		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	Green W	Count Cremetor 127 22. Name and Address of Facility	3-04 1:	reene Flueral Shur
8	Depa Impo any is		1 Laughn C	Dre :	8728 Liberty Ro	ndkandall	Stown, MD 24132
	Priysician		Immediate Cause (Final	cations that caused the death. Do not enter cause on each line.	nter the mode of dying, such as cardia  ( how Dewen		Approximate Interval Between Gnset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	stage (Johnson	1 64	Unknown
	LAGITITICI	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
	ecuted and transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
68760,	ficate be executed physician and is the burial-transit	al E	Toodking in death) East	Due to (or as a consequence of):			
_		Medical	IF FEMALE:				
Вох	death cert e attendin d for use	Physician/M	23b. Was decedent pregnant in the past 12 menths?		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
P.O.	at the d	Physi	9 Unknown	9□ Unknown			
Ś	The law requires that the death certif te has been signed by the attending vage 2 should be detached for use a	by	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	11	use contribute to the cause of death?
Vital Record	g 25 CA	Completed	periplen	I vasenlar disen	n i	24a. Was an	24b. Were autopsy findings available
al B				<u> </u>		autopsy performed? 1 ☐ Yes 2 ☐ K	
f ∑it	× ≅ ⊕	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	Oth	ome 5 Residence	6 Other (Specific)
o uo	ding Pt		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe how inj	
Division of	r Atten er deati rector: by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st	M 1 ☐ Yes 2 ☐ No treet, factory, office	28f. Location (Street a	and Number or Rural Route Number,
۵	pital or ours afte erel Dir illed in			building, etc. (Specify)		City or Town, Sta	te)
	To the Hospital or Attending Physicien; Within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director;	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledge, dear er: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the cause( rred at the time, date ar	s) and manner as stated.  nd place, and due to the cause(s)
	To th To th comp	Ž	29b. Signature and title of certifler		29c. License number	29d. D	ate signed (Month, Day, Year)
\			30. Name and address of person who con	npleted cause of death (Item 23a) (Type.	727569		12/3/08
			Vollen	Hettleman	1838 Green	2 Tru V	21 21208
	Stat Registra	_	31. Date filed (Month, Day, Year) DEC 0 3 2004	32. Registrar's Signature	Som to		

YNTH	IA BROV	IN	State of Maryland / Department of Health and M 1- State Unpend Item 23a-b&2/ per me G838 12-14-04 tas Certificate of Death	lental Hygi	ene 2004	38254
	Physici	an	1. Decedent's Name (First, Middle, Last)  CYNTHIA BROWN	Date of Death     Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) ST • AGNES HOSPITAL  4b. City, Town, or Location of Death BALTIMORE CITY		28, 2004 4c. County of Dea	1.
35	Funeral Director		5. Social Security Number 6. Sex 1	8. Date of Birth (Month, Day,	9. Bi	thplace (State or Foreign ountry)
	e Maryland le-f show lifted at	ctor	10a. State 10b. County 10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1恆Yes 2□No
	th with the M 23a or 28e-f at be notifie	ai Director	10e. Street and Number 4812 FREDRICK AVENUE 21229	10	g. Citizen of What C	ountry?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I feath and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Sprift Yes, specify Cuban, Mexican, Puerto 1 Yes, Sive 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	d within 72 ho giene. Ir than *natur The Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  RADE  16a. Decedent's Usual Occupation (Give kind of work done during most of works) life. DO NOT use retired)  IECHNICIAN	ing	6b. Kind of Business	ARE
Maryland (	12 should be filed within and Mental Hygiene. 7 Is marked other than raumatic evant, the M	To Be C	17. Father's Name (First, Middle, Last)  LEVERNUE TAYLOR, SR.  18. Mother's Name JANUE	LOWERY		
	and 2 shealth and m 27 ls m			ALTO. MI	0 21229	
3altimore,	Page nent o ant: If ury or		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	1.04 B	Oc. Location - City or ALTO - MO	
Ball	permit. Departr Importa any inji		21. Sign are of Funeral Service Licensee  22. Name and Address of Facility VAUGHN C- GREENE 5151 BAKO- NATU OR	FUNERAL E. BALTO	SERVICE MD 21	229
	Prysician /Medical Examiner	Examiner	23a. Part 1. Enter th) disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or hear failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Lister Underlying Cause (Disease or injury that initiated events  Cardiac arrhythmia  Due to (or as a consequence of):  Interstitial fibrosis  Due to (or as a consequence of):	и юзричогу апох		Approximate Interval Between Onset and Death
O. Box 68760,	ne death certificate be ex the attending physician hed for use as the buria	Physician/Medical Ex	Due to (or as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 5   Other (specify)   9   Unknown		23d. Date of de Month	ivery Day Year
0	uires that the signed by Id be detac	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			the cause of death?
al Records,	: The law requir cate has been s ; page 2 should	Completed		24a. Was an autopsy performe 1 \( \text{Yes} \) 2	ed?   death?	utopsy findings available completion of cause of
Division of Vital	Attending death. ctor: After y the fune	Certification: To Be	27. Manner of Death  1 Natural 5 Pending Investigation  2 Accident Injury (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  M 1 Yes 2 No  28e. Place of Injury - At home, farm, street, factory, office	me 5 Residen 28d. Describe how 28f. Location (Stre	ce 6 Other (Sperinjury occurred	
Ō	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, t	City or Town,	ise(s) and manner a	stated.
•	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one)  29b. Signature and title of certifier  29c. License number  O.C.M.E		d. Date signed (Moni	
	(J)		30. Name and address of person who completed cause of dea (Item 23a) (Type, Print)  111 Penn Street, Baltimo	ore, Mary	land 2120	1
	Sta Registr		31. Date filed (Month, Day, Year)  32. Refistrar's Signature			

DHMH 17 Rev 1/2001

		1 - For State Registrar  1. Decedent's Name (First, Middle, Last		ertificate of Death	Reg  2. Date of Death  Month	No. 2004 3825
Physici /Medic Examir	cal	John Y. Borkman 4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea	November	Day Year 28, 2004 12:30p 4c. County of Death
Funeral Director		212-20-3337	M 2□F 7. Age (In yrs. last birthda 79 Yrs.	Rockville  y) If Under 1 Year If Under 24 Hrs  Months Days Hours Min	8. Date of Birth	Montgomery  9. Birthplace (State or Fore Country)  Mary Land
a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Washingto	on Hagersto			10d. Inside City Lim 1 ☐ Yes 2 ☐
Jiane. rthan "naturel", or Items 23e or 28e-1 show It e Medical Exar. ir ar mast Le molified at	Funeral Director	10e. Street and Number  1106 Luther Dr.  11. Marital Status	12. Was Decedent Ever in U.S. Agged Forces?	10f. Zip Code  21740  3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer		Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.
naturel', or it	b	1 ☐ Never Married 2 ☐ Married 3 🌣 Widowed 4 ☐ Divorced  15. Decedent's Edu (Specify only highest grad	1 ↑ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 점 No Specify: Wh	ite 16	Specify: White
Hyglene. ither than " ant, the Me	Be Completed	Elementary/Secondary (0-12)  4  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	rement Director		ommunications  den Sumame)
and Menta Is marked sumatic ev	To B	John F. Borkman  19a. Informant's Name/Relationship (7)		iling Address (Street and Number or R		
ent of Health nt: If item 27 ry or other tr		Jeffrey Borkman - S  20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	20b. Place of Dis	Skymist Terrace,  position (Name of ematory or other place)  re Crematory Park  Dec.	Date 200	ryland 20832  Location - City or Town, State  altimore, Maryland
Department of h Important: If ite eny injury or of once.		21. Signature of Funeral Service Licens	angu 3	22. Name and Address of Facility Lo	udon Park Baltimore,	Funeral Home Maryland 21229
nysician Medical xaminer		Immediate Cause (Final	lications that caused the death. Do not enter the face on each line. a. Metastatic Rena1  Due to (or as a consequence of):		c or respiratory arrest,	Approximate Interval Between Onset and Death
cian and burial-transit	ical Examiner	if any, leading to immediate Cause (Disease or injury	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
hed by the attending physical detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
been signed by	leted by Pr	Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death
ite has page 2	Сотр				24a. Was an autopsy performer	24b. Were autopsy findings available prior to completion of cause death?  1 ☐ Yes XX No
fter this	ation; To Be	25. Was case referred to medical examiner?  1	Hospital: 1   Inpatient 2   ER/Outpati  28a. Date of Injury (Month, Day Year)   28b. Time Injury	ent 3 DOA Other: XX Nursing Not 28c. Injury at	ath (Check only one)  Home 5 Residence 28d. Describe how i	e 6 Other (Specify) njury occurred
within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, S	
in 24 ho he Fune pletely fi	Medical	29a. Certifier   I Certifying Phy (Check only one)   2   Medical Exami	rsician: To the best of my knowledge, de- iner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred at License number	urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)  Date signed (Month, Day, Year)
E = E		200. Digitature and Illigor Settings	11/	230. Elberise Hulliber	290.	Date Signed (Month, Day, Tear)

		For State Registrar	State of	Maryland	/ Depa	rtment of H	ealth and Death	d Mental Hyg	iene 00	4	3825	6
Physicia		1. Decedent's Name (First, Middle,	Last)					2. Date of Deat	h	'ear	3. Time of Deatl	h
/Medica			Bory					November	27, 20		9:30 A	М
Examine	r	4a. Facility Name (If not institution,		ber)		4b. City, Town, or		eath	4c. County of			
	-	8800 Walther Bl		. Age (In yrs. last	t hirthday)	Parkvi	LLE If Under 24 F	irs. 8. Date of Birth		timo	Te ace (State or Fore	
Funeral Director		214-18-7401	1 □ M 2 1 F	82	Yrs.	Months Days		in. (Month, Day, Feb. 5,	1922 N	Counti	land	ngn
P.		Usual Residence of Decedent						, , ,	1/22 1	Too Ligh	cara	
show	2	10a. State 10b. County		10c. City, T	own or Lo					10	d. Inside City Lim	
the M	Director	Maryland Balti  10e. Street and Number	more			10f. Zip Code	ville		ng. Citizen of Wha		1   Yes 2   X	140
d 21215-0036  filed within 72 hours after death with the Maryland Hygiene.  Hygiene, instural, or items 23e or 28e-f show ant, the Marical Exervities is usafter notified at		8800 Walther B	lvd.			101. Zip Code	2123			S.A.	ry r	
death	runeral	11. Marital Status	12. Was Deced	ent Ever in U.S.	13. V	Vas Decedent of His		(Specify Yes or No- erto Rican, etc.)	14. Race -	America		
or He		1 Never Married 2 X Married	Armed Ford 1 Yes 2 If Yes, Give	. □XNo			n, Mexican, Pu Specify:	erto Rican, etc.)	C/4	White, e		
hours tural:	o Dá	3 Widowed 4 Divorced	Year or Dat	es:						whit		
in 72	Diete	15. Decedent's (Specify only highest	grade completed)		(Give life. L	ent's Usual Occupa kind of work done d OO NOT use retired)	ation <i>luring</i> most of v )	vorking	6b. Kind of Busin	iess/Indu	ustry	
212 d with giene. ir thai	Completed	Elementary/Secondary (0-12) 12th Grade	College (1-4	tor 5+)		iner			Seakood	/Del	i	
al Hy	De	17. Father's Name (First, Middle, La	•					lame (First, Middle, M				
aryland 21215-0036 should be filed within 72 hours after death with the Marylan nd Mental Hygiene. markad other than "natural", or items 23a or 28a-f show imatic evant, it a Madical Executive is set in the inclined at	9	Andrew Potur					Veron		itys			
Marith ar 172 (18 27 is 27 is 17 au		19a. Informant's Name/Relationship Mrs. Elaine Bory						Rural Route Number, Phincoteagu				
Baltimore, Dermit. Pages 1 ar Department of Hea mportant: If Itam; any injury or other		20a. Method of Disposition 1 D Burial 2 D Cremation 3	□ Removal from St	20b. Place	e of Dispos etery, crem	sition (Name of patental)	9)	Date 2	Oc. Location - Cit	y or Tow	n, State	
Limor Pages tment of I tant: if its		` 4 □Donation 5 🛣 Other (Spe	city)Entombm	ent St.								
Baltimor permit. Pages Department of H Important: If its any injury or of once.		21. Signature of Euneral Service Lic	ensee					Chimunek F Baltimore			S	
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that cau	used the death. L						- /	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	101	ug chr	rcer	_				(	Onset and Death	
/Medical Examiner	-	resulting in death)	Due to (or	r as consequen	ce of):							
	5	Sequentially list conditions, if any, leading to immediate	b. Due to (or	r as a consequen	ce of):							
d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Underso or injury that initiated events			,-							
cate be executed physician and the burial-transit	LYB	resulting in death) Last	Due to (or	r as a consequen	ce of):							
physiciar the burin	2		d.							4		
	ME	IF FEMALE:	220 If you guitar									
that the death certification of the death of the death of the detached for use as	2 2	23b. Was decedent pregnant in the past 12 months?		h 2 Efetal dea nt at time of death	ath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date o Month	,	/ Pay Year	
S et to be	132	1  Yes 2  No 9  Unknown	9□ Unknow		, ,	other (specify)						
wrequires that the sbeen signed by the should be detached by the should be detached by the should be detached by the should be detached by the should be detached by the should be detached by the should be should be should by the should be should by the should be sho		Part II. Other significant conditions	contributing to dea	th but not resultin	g in the un	derlying cause give	n in Part I.	23e. Did toba	acco use contribu	te to the	cause of death?	
ord b								1 🗆 Yes	2 □ No 3 □	] Probat	oly 4 Honknov	wn
as b	2							24a. Was an autopsy	prior	e autops	y findings availab pletion of cause o	ole of
	5 _							perform	ed? deat	th? Yes 2		
OT VICAL P Phyaician: Th this certificate ral director, pag	ם ב	25. Was case referred to medical examiner?	Hospital:			Otho		eath (Check only one				
this al dii	- 1-	1 Yes 2 No  27. Manner of Death	1 □ Inp		Outpatient b. Time of	3 □ DOA Other	4 Livursing	Home 5 Resider		Specify)		
nding nding tth. :: Afte e fune		1-Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month,	Day Year)	Injury	Work'	? 'es 2 □ No	200. 20001.00 1107	injury cocurred			
DIVISION of all or Attanding F safter death. It Diractor: Atter I d in by the funers		3 ☐ Suicide 6 ☐ Could not determine	286. Place of	f Injury - At home, , etc. (Specify)	, farm, stre	et, factory, office		28f. Location (Stre City or Town,		r Rural F	Route Number,	-
ppital or Attan ours after deat naral Diractor; filled in by the	)							1				
To the Hospital of within 24 hours at To tha Funaral D completely filled in Martical Company of the complete of the complete of the complete of the complete of the company	alcai	29a. Certifier 1 Certifying 1 (Check only one) 2 Medical Ex	Physician: To the be aminer: On the bas and manne	is of examination	dge, death and/or inv	occurred at the time estigation, in my opi	e, date and pla inion, death oc	ce, and due to the cau curred at the time, dat	ise(s) and manne e and place, and	r as state due to th	ed. ne cause(s)	
To th withir To th comp	IA	29b. Signature and title of certifier	. 7		$-\Lambda$	29c. License	numbe	29	d. Date signed (N	lonth, Da	ly, Year)	
		15~	A11 ~	74		/ w)	リ	L4 67 C	11/20	10,	7	
12		30. Name and address of person wh	o completed cause	of death (Item 23	а) (Туре, F	rint) walt	ner Bl	od Paul	wille of	19.	21234	
State Registrar		31. Date filed (Month, Day, Year)  DEC 0 3 2004	32. Reg	istrar's Signature	Sp	als						

			1 = For State Registrar	State of Mary	land / Depa	artment of Heal rtificate of Dea	ith and Me			38257
			Decedent's Name (First, Middle, L.	ast)			2	Reg. No		3. Time of Death
	Physici /Medio		DONALD			BOESH	/	Worth Da	30,2000	-1
1	Examir	ner	4a. Facility Name (If not institution, gi	ve street and number)	fort	4b. City, Town, or Loca	ntion of Death	40	. County of Dea N/A	th
	Funeral		,	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If U	Inder 24 Hrs.   p	B. Date of Birth	Q Rie	tholace (State or Foreign
	Director		213-32-8304 Usual Residence of Decedent	1AJM 2UF 69	Yrs.	,	\ \	(Month, Day, Year, 100. 10, 1	935 Pe	nnsylvania
	aryland show	<u>_</u>	10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	the M. 28a-f	Director	Maryland N/A			Baltimor 101. Zip Code	.e	10g Ci	tizen of What Co	1 Yes 2 No
	th with 23a or		1034 Ewitt Way			21205		, rog. 0.	U. S. A	•
	er dea Items	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No	in U.S. 13.	Was Decedent of Hispani If Yes, specify Cuban, Me		fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	ncan Indian,
036	y within 72 hours after death with the Maryland liene. r than "natural", or items 23a or 28a-1 show Tre Medical Exertiret must be multified at	by	3 ☐ Widowed 4 🂢 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No Spe	ecity:		Specify: W	hite
15-0	"natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during DO NDT use retired)	most of working	16b. K	ind of Business/	
212		omo	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5+)	me.	Computer 0			Newsp	aper
Baltimore, Maryland 21215-0036	td be filed ental Hygia kad other ic evant.	Be	17. Father's Name (First, Middle, Las	')			Mother's Name (	First, Middle, Maider		
aryla	s 1 and 2 should t f Health and Ment itam 27 is markac othar traumatic	၉	Paul Boeshore  19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street and No	Grace 1		or Town State 2	in Code)
, Ma	t and 2 : Health ar am 27 is		Edward Boeshore			Ewitt Way,				
ore			20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 [	Removal from State	Ob. Place of Dispo cemetery, crei	sition (Name of matory or other place)	Dat	e 20c. Lo	ocation - City or	Town, State
Ħ			<ul> <li>4 □ Donation 5 □ Other (Special</li> <li>21. Signature of Funeral Service Lice</li> </ul>		St. Stan	SLAUS 2. Name and Address of F	12/03/	2004 Bal	timore.	Maryland
ñ	permit. Departr Importa any inji		Bum all	eller	3.	331 Brehms L	Lane, Ba	muner run ltimore, 1	erae Hor Md. 2121	nes 13
	Physician		Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition	one cause on each line.		er the mode of dying, suc				Approximate Interval Between Onsel and Death OUNS
	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):			1		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a sor	isaquence of).					
1.1	and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cor	sequence of):					
68760,	ficate be executed physician and is the burial-transit	edical E	· ·	d						
_	‡ on ea		IF FEMALE:	23c. If yes, outcome of pr	egnanov	_				
.O. Box	that the death certif ed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 4 Pregnant at time	Fetal death 3□	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
S, P	requires that the een signed by th nould be detache	by Pr	Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cause given in P	Part I.	23e. Did tobacco u	se contribute to	the cause of death?
ord	w requires that been signed be should be det	eted							□No 3□Pro	
Vital Record	The la ate has page 2	Completed						24a. Was an autopsy performed?	24b. Were au prior to death? 1 \( \text{Yes}	topsy findings available completion of cause of 2 No
	Physicien: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 ★ Yes 2 □ No	Hospital:	2 ER/Outpatien	04	Place of Death	Check onlone 5 Residence	C Cother (Cone	2.1
Division of	ng Phys fter this ineral di		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time of			d. Describe how injur		пу)
isio	Attanding or death. ector: After by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be	O Diese of leive	At home farm str	M 1 Tes 2		. Location (Street an	d Number or Du	rai Pauta Numbar
Ω	s after s after al Dire	Certif	4 Homicide determined	building, etc. (Sp		set, raciory, omce	201	City or Town, State		ar noute Wullber,
	To the Hospital or Attanding Ph within 24 hours after death.  To tha Funaral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 Certifying Pl	nysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, death mination and/or inv	occurred at the time, dat vestigation, in my opinion,	te and place, and death occurred	d due to the cause(s) at the time, date and	and manner as place, and due	stated. to the cause(s)
1	To t With To t	X	29b. Signature and title of certifier	1. Po		29c. License numb			e signed (Month	
			30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)	117 57	7 1. treet,	2/1/0	7
	10		Barbara K	Blok MLD	. 80	DO N. W	olfe 5	treet,	Balt	(MOYEM)
	Sta Registr	-3	31. Date filed (Month, Day, Year)  DEC 0 3 200	32. Registrar's S	ignature	South!				

			1 - For State Registrar	State of Mar		artment of H			giene Reg. No		38258
	Dhusisi		1. Decedent's Name (First, Middle, Last,	)				2. Date of De		Year	3. Time of Death
	Physici /Medio		Ca	therine Ma	rgaret Ba	SS		Novemb	-	2004	1:30 P M
	Examin	er	4a. Facility Name (If not institution, give	street and number)			r Location of Dea	th		County of Death	
			6713 Oak Avenue  5. Social Security Number 6. Se.	7 400	(In yrs. last birthday)	Dunc If Under 1 Year		8. Date of Bir	Baltimore		
	Funeral Director			M 20 F 77	Yrs.	Months Days	Hours Min	. (Month, Da	ıy, Year)	3.0	nplace (State or Foreign untry)
			Usual Residence of Decedent					Feb.	21,19	27   Mar	yland
	nylan show	_	10a. State 10b. County	1	0c. City, Town or Lo	cation					10d. Inside City Limits
	Ba-f s	Director	Maryland	timore				Dunda	alk		1 ☐ Yes 2½ No
	with th		10e. Stréet and Number			10f. Zip Code			10g. Citizo	en of What Cou	untry?
	s 236	erai	6713 Oak Avenue	12. Was Decedent Ev	orin II S 10.1		.222	3000 H. V N		ted Sta	
36	72 hours after death with the Maryland "natural", or Items 23e or 28a-f show alcal Everill et roust be recition at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cub □ Yes 2√ No		to Rican, etc.)		Black, White	
9	2 hot	ted	15. Decedent's Edu	cation	16a. Deced	lent's Usual Occup	pation		16b. Kind	d of Business/I	
215	⊆3	Completed	(Specify only highest grad	e completea) College (1-4or 5+)		kind of work done OO NOT use retire	-	rking	_		
21	filed with Hygiene. sthar thar	Cou	12 Years		Reta	ail Clerk					Retail
ınd	e d a d o o o o o o o o o o o o o o o o o	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	, Maiden S	Sumame)	
<u>\</u>	should be and Mental marked o	P P	Agustus Schmidt  19a. Informant's Name/Relationship (Tr	- Dian	401.14.75						kelmann
Z				, , ,		g Address <i>(Street</i> 7 Detroit		urai Houte Numbi Oundalk,	-		(1222
<u>6</u>	s 1 and 2 should of Health and Meritem 27 Is marke other treumatic		Mr. Wayne Bass / 20a. Method of Disposition	3011	20h Place of Disno	sition (Name of		Date		ation - City or T	
<u>0</u>	m O .		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Dopation 5 ☐ Other (Specify)		Oak Lawn	Comot Osc	1	004	Do 1.	t imoro	Marriand
Baltimore, Maryland 21215-0036	그 돈 만 글	1	21. Signature of Funeral Service Licens	1	22	Name and Addre	ss of Facility				Maryland
ä	Depar Impo		Wester Col			ida-Ruck 922 Wise					
	Priysician /Medical Examiner		23a Part1. Enter the disease or complished, or heart failure List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as a o	consequence of):	er the mode of dyir	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	bed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
_	cate be executed obysician and the burial-transit	Examiner		Due to (or as a c	consequence of):						
8760,	s be e sician burit				, ,						
687	ificate g phys as the	edic									
.O. Box	it the death certifics by the attending phached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	′		23	3d. Date of deliv Month	Pery Day Year
ords, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	ntributing to death but	not resulting in the ur	iderlying cause giv	en in Part I.				the cause of death? bably 4 □Unknown
Vital Records,	The law ate has b page 2 sl	Completed						24a. Was autor perio 1 Yes		24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
V Ita	Physician: This certifical	Be	25. Was case referred to medical examiner?	lospital:		Oth		ath (Check only o			
of		T. To	1 Yes No	1 Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of	3 DOA	4 🗆 Ivursing r	dome 5 Resident 28d. Describe to		Other (Speci	fy)
on	ding Ih. Th. After funer	tion	Natural 5 Pending 2 Accident investigation	(Month, Day Y	(ear) Injury	28c. injur Wor M 1 □	k? Yes 2 □ No	2001 2000120	io ii ii iio y	00001100	
Division	tal or Attanding s after death. al Diractor: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, farm, stre (Specify)	eet, factory, office		28f. Location (\$ City or Tox		Number or Run	al Route Number,
	To the Hospital or Al within 24 hours after of To tha Funeral Dirac completely filled in by	edical	29a. Certifier Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Certifying Physical Certifier Certifying Physical Certifier (Certifying Physical Certifying Physical Certifier Certifying Physical Certifying Physical Certifier (Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifier (Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifier (Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifier Certifying Physical Certifying Physical Certifier Certifying Physical Certifier Certif	sicien: To the best of a ner: On the basis of ex and manner state	kamination and/or inv	occurred at the tine stigation, in my o	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) ar date and p	nd manner as s place, and due t	stated. o the cause(s)
)	Vith Correction	M	29b. Signature and title of certifier	Stall Pyre	Uhr.	29c. Licens	e number		29d. Date $11/30$	signed (Month,	Day, Year)
	<b>'</b> )		30 Name and address of person who co	J48UMC	4970 12	Print) KTPKY	Ne R	(1) mar	, rd	1-122	4
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's	s signature	, ,					
DH	MH 17 Rev 1/2		DEC_03	2004	exerce /	1 do	acts/				

ORIGINAL

			1 - For State Registrar	State of Marylan	d / Depa		lealth and	Mental Hyg		
	Physici /Medi	al	1. Decedent's Name (First, Middle, Last					2. Date of Dea Month	Day Year	04 10 - 58 M
	Examir Funeral Director	er	212-12-1267	Joien Cone			If Under 24 Hrs Hours Min.	8. Date of Birtl		arte 1
	th the Maryland or 28e-1 show e noillise at	Director	Usual Residence of Decedent	10c. City	, Town or Lo		dgemère		10g. Citizen of What (	10d. Inside City Limits 1 ☐ Yes 2 ⊠ No
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23a or 28e-f show or other freumatic event, the Medical Examiner must be natified at	by Funeral	3115 Lynch Roa  11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	td.  12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cubi I ☐ Yes 212 No		Specify Yes or No- to Rican, etc.)	United St  14. Race - Am Black, Wh  Specify:	erican Indian,
21215-0036	filed within 72 hor Hygiene. other than "natura ent, the Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12 Years	cation le <i>completed)</i> Callege (1-4or 5+)	(Give life. l	lent's Usual Occup kind of work done DO NOT use retired ecretary	during most of wo		16b. Kind of Busines Baltimore Traff	Transit
Maryland	12 should be fill and Mental H and Mental H 7 le marked ott reumatic even	To Be	17. Father's Name (First, Middle, Last)  Roy Roth Louden  19a. Informant's Name/Relationship (T)  Mrs. Barbara Her			-	Ma: and Number or Ri	me (First, Middle, rie Barba ural Route Numbe ndalk, Ma	ara Wise r, City or Town, State,	Zip Code) 1222
Baltimore, I	permit. Pages 1 and 2 Department of Health Importent: If Item 27 any injury or other tre once.	0	20a. Method of Disposition  12 □ Cremation 3 □ F  14 □ Donation 5 □ Other (Specify)	Removal from State 20b. Processing Co.	lace of Dispo emetery, crem ak Law	sition (Name of natory or other place n Cemete:	ry 11/2	Date 7/2004	20c. Location - City o	rTown, State e, Maryland
Ba	permit. Pa Departmer Importent any injury		21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final	ications that caused the death	79	22 Wise	Ave. Du	ndalk, Ma		1 2 2 2  Approximate Interval Between Onset and Death
10000000	/Medical Examiner	Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause 10 season of injury that initiated events	Due to (or as a consequence to consequence)	2	Ω				-Durch
Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	cal	IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consequed.  d.  23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal	ncy _	Ectopic pregnancy	- 2002		23d. Date of de	•
P.O.	S L 90	by Physiclan/Med	In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions con	4☐ Pregnant at time of de 9☐ Unknown	eath 5	Other (specify)			Month bacco use contribute	
al Records,		Completed by	Small Bowel O	betweetion	Ile	OTTOMY		24a. Was a autops	tn 24b. Were a prior to death?	utopsy findings available completion of cause of s 2 \( \sum \) No
Division of Vital	Attending Physicien: r death. sctor: After this certifici	ation; To Be	27. Manne of Death  1 Natural 5 Pending 2 Accident investigation		ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 Nursing H		ne) ence 6 ⊡Other (Sp ow injury occurred	acity)
Divis	To the Hospital or Attending Ph. within 24 hours atter death. To the Funerel Director: Atter thi completely tilled in by the funeral	al Certification;	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify sician: To the best of my known	vledge, death	occurred at the tir	ne, date and place	City or Town	ause(s) and manner a	s stated.
)	To the Ho within 24 h To the Ful completely	Medical	(Uneck only one)  2 Medical Exami  29b. Signature and title of certifier	ner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my o	pinion, death occu	urred at the time, d	ate and place, and du 9d. Date signed (Mon	e to the cause(s) th, Day, Year)
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signat			INS B	AyviEn	Vovember 2	T
	Regist	ar	DEC 0 3 2004	for the	1.					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Phyllis Phyllis Marie Blanton 25 OUPUNUSON 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore City N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) NOV. 5,1929 Funeral 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Months Days Hours Min 1 - M 2XX 579-34-2311 75 Yrs. Director Tennessee Usual Residence of Decedent death with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturat", or items 23s or 28s-f show traumatic avent, the Medical Examinat must be indiffied at 1 ☐ Yes 2 No Director Maryland Rosedale Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7804 Bluegrass Road 21237 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. ant: If Itam 27 Is marked othar than "naturat", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Ernest Goodnough Mary Stinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Oscar J. Blanton/Husband 7804 Bluegrass Road Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ö permit, Page Department of Important: If any njury or once Hilltop Service Corp. 12/1/2004 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician oronovy avtery wouth /Medical Examiner hpunic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner I Records, P.O. Box 68760, burial-transit Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? , page 2 s certificate 1 Yes 2 No 2 No Division of Vital 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Director Completely filled in 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) rouver MI 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) GVOSSMAN 201 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ivia	Cei	tificate of i		Reg	2004	38261
1	Dhysisi		1. Decedent's Name (First, Middle, La	st)			2	. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		James Br	ırton	Beek		N	ovember	28, 2004	7:55 P M
	Examin	er	4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death		4c. County of Death	
			7401 Westlake To			Bethes If Under 1 Year	I to a decident		Montgo	
	Funeral Director		5. Social Security Number 6. S 217-65-5716  Usual Residence of Decedent	M 2□F	(In yrs. last birthday) 55 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Yune 2, 1	ear) 9. Birth Cou	place (State or Foreign intry) yland
	/land		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Man me-f sh	tor	Maryland Montgon	nerv	Ве	ethesda				1 ☐ Yes 2√€ No
	th the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	intry?
	23a		7401 Westlake Te				817		nited Stat	es
	er de:	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Speci In, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
35	irs aft		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10	1 ☐ Yes 21X No	Specify:		Specify: Wh:	ite
5	2 hou	Completed by	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	16	b. Kind of Business/li	ndustry
216	thin 7	nple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+) (Give	NOT use retired	during most of working ()			
5	ygien ygien t, tre	Con		4	Spee	ch Write			Federal Go	vernment
2	be fill Hall He off	Be	17. Father's Name (First, Middle, Last James William	, Beek			18. Mother's Name (		,	
1	hould d Mer mark matic	은	19a. Informant's Name/Relationship		10h Mailir	o Address (Street	and Number or Rural I			in Codo)
N	id 2 s ith an 27 is treu		Jennifer A. Smith				Terrace,			
9	t Hea		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Dat	9 20	c. Location - City or T	
Ē	Page nent o nnt: If iry or		1 ☐ Burial 2 ☑ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Special		Montg	natory or other plac omery itorium.	2001	•	thesda, M	arvland
Pattimore Menyland 21915,0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In Important if the M71 is marked other than "naturel", or itema 23a or 28a-f show any injury or other treumatic event, it a M73Ical Examinar must be notified at 900cs.		21. Signature of Funeral Service Lies	TSBe						neral Home/ onsin Avenue
0	3 89229		1 Caur		101200 BE	tnesda,	Maryland 2	U814-35C	11	nsin Avenue
			23a. Part1. Enter the disease, or comshock, or heart failure. List only						,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	<u>a.</u>	oscietoric	Citadio unts	CULAR DI	SENTSE		ongot and boatt
	/Medical Examiner		<b>1</b>	*	a consequence of):					
		er	Sequentially list conditions, if any, leading to immediate	b	a consequence of).		-			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						
_	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a	a consequence of):		-			
09289	ate be hysici the bu	edical		d						
			IF FEMALE:	222 14						
9	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
	es that the death cer igned by the attendin be detached for use	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	ano or dodain	Cities (apeciny)				
٥	s that ned b	by PI	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
70	w require been sig should b	ed t	DERNESSIEN					1 🗌 Yes	2□No 3□Pro	bably 4 \ Unknown
A A Vital Boogade	The law requires that the death cell that been signed by the attending page 2 should be detached for use	Completed						24a. Was an autopsy	24b. Were autoprior to co	opsy findings available ompletion of cause of
₹ 6	ding Physicien: The lav h. After this certificate has funeral director, page 2	Соп						performe 1 ☐ Yes 2 🗶	d? death?	2 No
/#	Physiclen: this certific	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death (			
4	Phys this ral dir	2	1 ☑ Yes 2 ☐ No  27. Manner of Death	1 L Inpatie	nt 2 ER/Outpatien		9r. 4 Nursing Home	<ul> <li>5 ☑ Residence</li> <li>d. Describe how</li> </ul>		fy)
2	th. After	tlon	1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injur (Month, Day	Year) Injury	Worl	k? Yes 2 □ No	G. 20001100 11017	injury boodings	
	Attending r death. sctor: After by the fune	iflca	3 Suicide 6 Could not be determined	e 28e. Place of Inju	iry - At home, farm, str	eet, factory, office	28	f. Location (Stree	at and Number or Rur	al Route Number,
Ĉ	s afte	Certification:	4   Holinide	building, etc	. (Зреспу)			City or Town, S	otate)	
	To the Hospitel or Attendi within 24 hours after death. To the Eunerel Director: A completely filled in by the fo	Medical	29a. Certifier 1 ☐ Certifying PI (Check only one) 2 ☑ Medical Example (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination and/or in-	n occurred at the time restigation, in my of	ne, date and place, and pinion, death occurred	d due to the caus at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		P >	29c. License			Date signed (Month,	
	,			W	mo (one)	01	5236	No	JAM GGL 30,	1004
-	5		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, 125 Pock Vive	Print) 6 Pike 120	ervice, MO	∿085℃		
	Sta Registr		CRRL I. WARGO 31. Date filed (Month, Day, Year) DEC 0 3 2004	22. Registra	ar's Signature	bouls				

				1 - State of Maryland / De State of Maryland / De	partment of Health and Mertificate of Death	ental Hygiei	2004	38262
		Physici		Decedent's Name (First, Middle, Last)  JAMES ALBERT BLOODSWORTH		2. Date of Death Month NOVEMBER		3. Time of Death 8:15 A M
		/Medic Examir		4a. Facility Name (If not institution, give street and number)  JOSEPH RICHEY HOSPICE HOUSE	4b. City, Town, or Location of Death BALTIMORE CITY	1	4c. County of Death BALTIMOR	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye 9-3-1932	9 Riethol	ace (State or Foreign
	-	Director		Usual Residence of Decedent		9-3-1932		
		Marylan a-f show	tor	10a. State         10b. County         10c. City, Town of the county           MD         ANNE ARUNDEL         GLE	N BURNIE		10	0d. Inside City Limits
		with the M. Se or 28a-1	Director	10e. Street and Number 964 PRINCETON TERRACE	10f. Zip Code 21060	10g.	Citizen of What Coun	try?
	9	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23e or 28e-1 show ant, it e Modical Exarch er coust be notified at	Funeral		3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, 6	
	5-003	72 hours "natural",	ted by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. D.	ecedent's Usual Occupation	16b	Specify: WIII	
٤	21215-0036	l within 7 iene. r than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	iive kind of work done during most of work e. DO NOT use retired) URITY		U.S. ARMY	
N	and 2	I be filed ntal Hyg ad otha avant,	Be C	17. Father's Name (First, Middle, Last)  GEORGE BAINE BLOODSWORTH	18. Mother's Name	e (First, Middle, Maid	den Sumame)	
00	lary	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "naturany injury or other traumetic avent, it a Mudical Once.	10	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Run	al Route Number, Cit	ty or Town, State, Zip	,
4	re, N	is 1 and of Health itam 27 othar tr		20a. Method of Disposition 20b. Place of D	PRINCETON TERRACE, sposition (Name of crematory or other place)		NIE, MD 21  Location - City or To	
hay a	Baltimore,	it. Page intment c intant: If njury or		I Li Buriai 2 XI Cremation 3 Li Removal from State			EVENSVILLE	
13	Ba	Department of the population o		> Muchille Cooney M0/4/5	1 SECOND AVENUE S.	W., GLEN		
~		Pnysician		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	-	or respiratory arrest,		Approximate Interval Between Onset and Death
		/Medical Examiner		disease or condition resulting in death)  Due to for as a consequence of:	21			months
~	)e/	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase of hair) that initiated events  c.				
Wart	, ,	sician and burial-transit	Examiner	that initiated events resulting in death) Last   C. Due to (or as a consequence of):				
_	68760,	ificate b g physic as the bi	ledica	d				
2) oods	O. Box	To tha Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To tha Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	y Day Year
0	ords, P.	n requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
anes	al Record	sician: The law n certificate has be rector, page 2 sh	Completed			24a. Was an autopsy performed' 1 🗆 Yes 2 🖼	? death?	sy findings available apletion of cause of
20	of Vital	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner?  1   Yes   2   No	Othor	n <i>(Check only one)</i> me 5 ☐ Residence	6-Dother (Specify,	Hospice
<i>Y</i> )		nding Ph tth. : After th s funeral		27. Manner of Death  1 Adural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Tim	e of 28c. Injury at	28d. Describe how in		
	Division	tal or Attendi s after death. al Director: A ad in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
		To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, do and manner stated.				
4		To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	1	Date signed (Month, D	
		0		30. Name and address of person who completed cause of death (Item 23a) (Ty	D24170	INC	ovember 3 MD Zizo	1,2004
		Sta	ite	31. Date filed (Month, Day, Year)  Richey Hospice 838  32. Registrar's Signature	•	ltimore)	VID 2120	1
	×.	Registr	1.	IFG 0 3 2004 Seneral	5 Sparks			

State of Maryland / Department of Health and Mental Hygiene () () 1 - For State Registrar 38263 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** BERLIN HERBERT ,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Maryland Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth FEB. 9, 1936 Birthplace (State or Foreign Country) Days Hours 1 M 2 □ F 68 219-32-4878 Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits other traumatic event. The Medical Examiner must be notified at Director N/A BALTIMORE 1 X Yes 2 □ No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 2700 N. CHARLES STREET 21218 USA Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 la marked other than "natural", or liarr any injury or other traumatic event. the Wedgest Examina-1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DELIVERY MAN SODA DISTRIBUTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BERLIN NOVAK ပ SAMUEL YETTA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1528 HOPEWELL AVENUE - BALTIMORE, MD 21221 REBA BROTHERS / SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. 12/02/2004 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Dust (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Phyaician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 🕏 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 finpatient 2□ER/Outpatient 3□DOA this 27. Manner of ath ate of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygier 1 38264 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Agnes (nmn) Beck 29, November 2004 7:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center @ GBMC Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 280 F Yrs. Director 79 220-14-3988 Aug. 18, 1925 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 ie marked other then "natural", or Itame 23a or 28a-f show traumatic event, Ins Medical Examiner must be notified al 1 ☐ Yes 2√2 No Directo Maryland Harford Hydes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3009 Harford Road 21082 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. onto it its marked other then "natural; or its lay or other treatmatic event, the Medical Examinary or other treatmatic event, the Medical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Godfrey Moran Sophia (nmn) Albers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2016 Schuster Road, Jarrettsville, MD 21084 Paula Webb / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) 12-3-04 Fork Christian Cem. Fork, Maryland 22 Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician men ease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or injury that initiated events Due to (or as a consequence of): Examiner igned by the attending physician and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 2∏ No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Nother (Specify) Hospice this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 1🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 25205 Novembe 30, 200 K w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Riles 21204 6601 N. Charles Street Baltimore, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Seck, Agnes 11/29/04@ 1940

11/28/04 @ 9.450m ANTHONY

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 38265 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Anthony 13047Eg MBER 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAITIMURE If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1☑M 2□F Yrs. Director 62 DEPLEMBER 6, 1955 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked othar than "netural", or Itams 23a or 28a-1 shov othar treumatic avant, the Mydical Experience in usi to a colline of 1 Yes 2 No Director BRITIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2138 STREET 21818 1.6.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 3 Widowed 4 Divorced Specify: Black 2 should be filed within 72 hours n and Mental Hygiene. Is marked othar than "netural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automobiles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BAILE AAM85 19a. Informant's Name/Relatio ip (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health itam 27 I 3209 EpupVIEW AVE Bestimore May/and 2/2/3 1)Ebrah 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1, Burial 2 □ Cremation 3 □ Removal from State ŏ Department of Importent: If any in ury or once. ` 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY In Homens TEHS 22. Name and Addre & of Facility 21. Signature of Funeral Service Licensee FUNERAL Catuera Buto 54 BAILIMERE 1129 N. CALULINE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 100 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner law requires that the death certificate be executed Cause (Discase or Injur that initiated events resulting in death) Last for use as the burial-tran Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tes 2 No 25. Was case referred to medical 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS Picc 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attanding Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, d 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SI Riseberg 301 Paul 31. Date filed (Month, Day, Year) QEC 0 3 2004 32. Registrar's Signature State Registrar

			1- For State of M		partment of Health and e <i>rtificate of Death</i>		2004 3	8266
	0	Ü	Decedent's Name (First, Middle, Last)		ortinoato or Boatin	Reg. 2. Date of Death		3. Time of Death
	Physici /Medic		Samuel P. Ca	Idwell	\	November	30 2004	4:40 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	1	4b. City, Town, or Location of Dea	ath	4c. County of Death	
H	Francis			nese (In yrs. last birthda	Buttonere  y) If Under 1 Year   If Under 24 Hi	rs. 8. Date of Birth	9 Birtholos	e (State or Foreign
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	r 28a-	Director	10e. Street and Number	1 Det 1 1	10f. Zip Code	10g.	Citizen of What Country	1?
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	tams	Funeral	11. Marital Status 12. Was Decedent Armed Forces	Ever in U.S.	3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Black, White, etc	
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ary	should be ind Mental ind marked c	<sup>C</sup>	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street and Number or F		ty or Town, State, Zip Co	ode)
	s 1 and 2 should f Health and Men item 27 is marke other treumatic		Samuel P. Caldwell	58		I Rd Col	umbis MID	21045
w	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		position (Name of rematory or other place)		Location - City or Town	
E	Pa nen nen nen nen ry		`4 ☐ Donation 5 ☐ Other (Specify)				Bulto M.	ite mo
Ba	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee		22. Name and Address of Facility &			1133
		_	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	the death. Do not e	enter the mode of dying, such as cardi	ac or respiratory arrest,	A	pproximate iterval Between
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	/Medical Examiner			a consequence of):	7			,
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ה ס	ding Pt h. After th funeral	ou:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury	Work?	28d. Describe how in	njury occurred	
DIVISION	if or Attendi after death. Director: A I in by the fu	icat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of In	ury - At home, farm, s	M 1 Yes 2 No	28f Location (Street	and Number or Rural Re	oute Number
2	spitef or A ours after nerel Direc filled in by	Certification;	4 Homicide determined 289. Place of in building, et	c. (Specify)	arost, ladory, onlos	City or Town, St.		outo Number,
	ospite hours unere		29a. Certifier  (Check only  2 Medical Exeminer: On the basis of	of my knowledge, de	ath occurred at the time, date and place	e, and due to the cause	e(s) and manner as state	d.
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	Medical	one) and manner st	ated.				
	5 <u>w</u> i	-	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day	
2			30. Name and address of person who completed cause of c	leath (Item 23a) (Tvn	9. Print)		vovember 3	1004
	V		Dr. Tarig Khan M.	). 2401	1	ere Ave	Baltmare	MD 21215
:	Sta	te .	31. Date filed (Month, Day Year) 32. Registr	ar's Signatura	Sparker	,		

Knain as:

			1- State of Maryland / Department of Health and M Certificate of Death	ental Hygie	ZUU4 38/6/
	Physic			2. Date of Death Month	Day Year 3. Time of Death 3. 7 Jan A M
	/Medi Examii		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  3509 HILLCresT AVE  BALTIMOR	e e	4c. County of Death  Bouth Mare
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In vrs. last birthday) Yrs.  7. Age (In vrs. last birthday) Yrs.  1 Usual Residence of Decedent	8. Date of Birth Month, Day, Ye 7 66 26	9. Birthplace (State or Foreign Country) M.).
	death with the Maryland ms 23a or 28a-f show Froust be notified at	Director	10a. State  10b. County  10c. City, Town or Location  PARKUILLE		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with th 23a or 28 ast be no	ai Dire	10e. Street and Number 10f. Zip Code 21234	10g.	Citizen of What Country? U.S.A
980	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene.  If item 27 is marked other then "neturel", or items 23a or 28a-f show or other treumatic event, I'm Medical Evarurat must be notified at	by Funeral	If Yes, Give 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 hogiene. giene. er then "netu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)	ing 16t	. Kind of Business/Industry  Home
Maryland	rould be file I Mental Hy Narked oth Natic event	To Be	Page 17. Father's Name (First, Middle, Last)  18. Mother's Name  Page 17. Father's Name (First, Middle, Last)  18. Mother's Name  Unit	(First, Middle, Main	
	and 2 sh salth and n 27 Is rr		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura  WAYNE CARROLL 2509 HILLCREST AVE.		
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.			Date 200	SALGO City or Town, State
Balt	permit. Pa Departmen Importent: eny injury		21. Signature of Funeral Service Licensee  22. Name and Address of Facility HARTLEY Miller - STE 7527 halfold RD	ella Frnes	ial Home CHID.
	Pnysician /Medical	V 1	23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	or respiratory arrest,	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Listease or in july that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):		
O. Box 6	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 Dato 9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 5   Other (specify) 9   Unknown   1   Unknown   1   Unknown   23c. If yes, outcome of pregnancy 3   Ectopic pregnancy 5   Other (specify)   1   Ves 2 Dato 9   Unknown   23c. If yes, outcome of pregnancy 3   Ectopic pregnancy 5   Other (specify)   1   Ves 2 Dato 9   Unknown   1   Ves 2 Dato 9   Unknow		23d. Date of delivery Month Day Year
rds, P.	w requires that been signed I should be det	by	A control significant conditions contributing to death but not resulting in the underlying cause given in Part i.	23e. Did tobacc	co use contribute to the cause of death?
al Records,		Completed	Complet	24a. Was an autopsy performed 1 Yes 2	
Division of Vital	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification: To Be	examiner? 1   Yes   2   No	ne 5 esidence 28d. Describe how in	njury occurred
Divi	itel or Att irs after d rel Direct led in by	Certifi	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	ledical	29a. Certifier (Check only one)  29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place at the companient of my knowledge, death occurred at the time, date and place at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of	and due to the cause ad at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
	with To Com	W	1B194.Roy ms. D36846		Oate signed (Month, Day, Year) (tm Btn 2, 2004
	ŋ		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERNAND IF RAVITEM SUN SUN	E208-17 B	CHIMINE OND 21209
	Sta Registr	-			

	1 - For State Registrar		d / Department of I Certificate of	Death	Reg. I	2004	38268
Physician /Medical	1. Decedent's Name (First, Middle, Las WANDA	LIFF		1	MON 3	Day Year Year S 2004	3. Time of Death
Examiner	4a. Facility Name (If not institution, give BON SECOUR 5. Social Security Number 6. S	HOSPITA	В	or Location of Death altimore Ci		4c. County of Death N/A	olace (State or Foreign
Funeral Director		OM 29 F 71	Yrs. Months Days	Hours Min.	Month, Day, Yea	ar) Coun	t Virginia
vith the Maryland or 28a-1 show be notified at	10a. State         10b. County           Maryland         N/I           10e. Street and Number		y, Town or Location  Balt  10f. Zip Code	imore City	100	Citizen of What Coun	0d. Inside City Limits  MXYes 2 □ No
h with t	820 South Caton	Avenue Apt.		229		ited State	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other traumatic event, 13. Medical Examinar must be notified at once.  To Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2010 No If Yes, Give Year or Dates:	S. 13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify:	
ed within 72 houygiene.  The then "nature to the Medical Et. t	15. Decedent's Ec (Specify only highest gra		16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	7	Kind of Business/Ind	
vid be filed v Mental Hygie Arked other stic event, th	17. Father's Name (First, Middle, Last)		Nurse	18. Mother's Name (	First, Middle, Maid	Home Care en Sumame)	Provider
and 2 shou allth and N. 27 is mail or trauma	19a. Informant's Name/Relationship (	Type, Print) Son	19b. Mailing Address (Street 26217 Jones				Code) 0636
Pages 1 and of the part: If item arry or other	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  1 ☐ Other (Specif.	Removal from State	lace of Disposition (Name of emetery, crematory or other pla udon Park Ceme			Location-City or To Baltimore	wn, State , Maryland
Dall.  permit. Departr Importe any inji	21. Signature of Funeral Service Licer	E. Kent	7922 Wise	ess of Facility Funeral Ho Ave. Dunc	Halk. Mar	197-1-198	c. 222
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be executed be executed burial-transit burial-transit	cause. Enter Underlying Cause (Dispass of Injury) that initiated events resulting in death) Last	b. Due to (or as a consequence					-
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The lar					24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ 1	prior to con death?	psy findings available inpletion of cause of
ysician: The lis certificate had director, page	examiner?	Hospital: 1 Inpatient 2 🗆	ER/Outpatient 3□ DOA Ot	26. Place of Death ( her: 4 Nursing Home		6 □Other (Specifi	<i>(</i> )
DIVISION OF VITAL  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,  Medical Certification: To Be C			28b. Time of Injury M 28c. Inju	ny at 28 ork? ] Yes 2 □ No	3d. Describe how in	jury occurred	
pital or Att urs after d arel Direct illed in by					City or Town, Sta		
the Hosp thin 24 hou the Fune impletely fil	(Check only 2 Medical Exer	niner: On the basis of examina and manner stated.	tion and/or investigation, in my	opinion, death occurred	d at the time, date a	and place, and due to	the cause(s)
To with To cor	29b. Signature and title of certifier  R- W- Short	<b>~</b> 9	D 00	119668	. 170	v 25 2	004.
5	30. Name and address of person who R. M. SHAH or SHAH or 31. Date filed (Month, Day, Year)	completed cause of death (Item	1 23a) (Type, Print)	J. Bal	n More	2 . MD	ŧ
State Registrar	050		ture				

DHMH 17 Rev 1/2001

ORIGINAL

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month CHAR! TONK -Ang L poulse 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Augsburg Lutheran Nursing Home Baltimore Lochearn If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 30, 1928 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 12 M 2□F 214-24-4381 76 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 MNo Maryland Baltimore Lochearn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Campfield Road 21207 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ▼ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 I No Specify: Specify: White 3 ☐ Widowed 4 ■ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Exxon Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Charitonuk Katherine Enke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17903 Marshall Mill Road, Hampstead, Maryland 19a. Informant's Name/Relationship (Type, Print) Mark Charitonuk 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Naven Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 12-03-04 Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses McCully-Polyniak Funeral Home P.A. 21230 130 East Fort Avenue, Baltimore, Maryland 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 3 □ Probabiy 4 □ Unknown 1 Tyes 2)=1No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Examiner or Attending Physician: The law requires that the death certificete be executed the burial-transit and Box 68760, Division of Vital Records, P.O. Certification: To

Physician/Medicai þ Completed Be

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**Physician** 

Examiner

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Director

r than "naturel", or items 23e or 28a-f show the Medical Examiner must be notified at

it of Haalth and Mental Hygie If item 27 is marked other or other traumatic event, I

Department of H important: If Ites

**Physician** 

/Medical Examiner

injury or other

Peges 1 and 2 should be filed within 72 hours after death with the Marylenc

Baltimore, Maryland 21215-0020

/Medical

within 24 hours after death.

To the Funeral Director: Af
complately filled in by tha fu i Director: A the Hospital

State

Registrar

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5. Was çase referr	ed to medical				26. Place of De	eath (Check only one)		
examiner? 1 ☐ Yes 2 2	No	lospital: 1   Inpatient 2	ER/Outpatient	3□ DOA	Other: ursing	Home 5 ☐ Residence	e 6 □Other	(Specify)
7. Manner of Death 1 ☐ Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	njury occurre	d
3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stree	et, factory, c	office	28f. Location (Stree City or Town, S		or Rural Route Number,
9a. Certifier (Check only one)		sician: To the best of my knoner: On the basis of examina and manner stated.						
Oh Signature and	title of certifier			29c I	icense number	294	Date signed	(Month Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUBMD AROUD

31. Date filed (Month, Day, Year) DEC 0 3 2004 32. Registrar's Signature

DIS872 December 1 2004 N. Rendender Md 21136

	-07463	4 11 1	Please	Type or Print in B	lack Indelible	Ink. Ensure All	Copies Are	e Legible.
MA			1- State Unpend Item	State of Maryland 23a-b,pt.II,27	d / Department <b>per me</b> (83) d / Department	of Health and Me 3 12-8-04 tas of Death	ntal Hygier	2004 38270
	Physici /Medic		Sandra Kandra		nnis	2	Date of Death Month November	20, 2004 3. Time of Death 0020 A M
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	Funeral		Johns Hopkins Hos 5. Social Security Number 6. So		ast birthday) If Under 1		. Date of Birth	9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent	DM 216 3.	5 Yrs.	Days Hours Min.	Month, Day, Yea Ug. 24, 15	169 Maryland
	e Marylaı 38-f show	ctor	MD 10b. County NA	Ba Ba	Town or Location			10d. Inside City Limits 1 (2 Yes 2 ☐ No
	ath with th	Funeral Director	2037 JEFFERS	on St.	10f. Zip 0	224		Citizen of What Country?
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ţ	thent of the trent of the trent. If it		' 4 ☐ Donation 5 ☐ Other (Specify	bacr			04 Dur	ndalk, MD
Bal	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Vineral Service Licen	24	22. Name and	Address of Facility	o Fredhil	21229 Iton Pass Belto., mD
	Physician		23a. Part I. Enter the disease, or comp shock, of heart failure. List only of Immediate Cause (Final disease or condition	dications that caused the death. one cause on each line.  Cardiac arryh				Approximate Interval Between Onset and Death
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Sorc	w requir been si should	eted	Hypertension; end	stage kidney d	itsease; niv	sero positiv	27	2 No 3 Probably 4 Unknown
Vital Records,		Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
	yeicie is certi directo	o Be	25. Was case referred to medical examiner?  1 ∑Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 🛣 E	FR/Outpatient 3 □ DOA	Other:		6 ☐Other (Specify)
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	To t To t	Σ	29b. Signature and title of certifier	4.0	29c. l	icense number	29d. D	ate signed (Month, Day, Year)
,			30 Name and address of passes who	ompleted cause of death (literal)		.C.M.E.	Nov	vember 20, 2004
			30. Name and address of person who d	te, MO	111 Penn	Street, Balt	imore. Ma	arvland 21201
E.	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 3	32. Registrar's Signatu	ire & Sparke			

		1 - For State Registrar	State of Marylar		artment o		d Mental Hy	giene	÷ 38271
Physic		1. Decedent's Name (First, Middle, La JESS Y C.	A L.	DOUC	SLAS	<del>&gt;</del>	2. Date of De Month	ath	ear 6 45 M
/Med Exami Funeral	ner		. 1		GW) If Under 1 Ye		SAK	4c. County of  34C th ay, Year)	Death  TIMORE  Birthplace (State or Foreign Country)
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ore, Ma		19a. Informant's Name/Relationship  MICHAEL DO  20a. Method of Disposition  1 Desurial 2 Cremation 3	20b.	S60 Place of Dispo	Address (Str. Str. Str. Str. Str. Str. Str. Str.	ZOX R	Paral Route Numb	er, City or Town, Sta FM OVE 20c. Location - Cli	, MD 2627
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Jing Jing After fune	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not determine	be 29 a Bloom of Injury. At h	28b. Time of Injury	М	Injury at Work? 1  Yes 2 No			or Rural Route Number,
Division  To the Hospitel or Attent within 24 hours after deatt To the Funerel Director: completely filled in by the	edical C		Physician: To the best of my kn aminer: On the basis of examin and manner stated.						
To the within To the compl	Me	29b. Signature and title of certifier	ATTOWN!	NG	29ç. Lic	4039	0	29d. Date signed (I	
V		30/Name and address of person with a state of the state o	o completed cause of death (Ite  Who 23 CND  32. Registrar's Sign	5310	Print) 1/	n. FF3	ZZ OWI	Was MI	us, M2111
S Regis	tate trar	DEC 0.3 200	1	ha	K)				

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otate of ivi	arylana /		cate of	Death		Reg. No. 200	4 38272
	Physicia	q	1. Decedent's Neme (First, Middle, L	ast)					2. Date of De Month	eth Day Ye	3. Time of Death ar
	Physicia /Medic		Jean S. Dunl	ор					Decembe	er 1, 200	
	Examin		4a Fecility Neme (If not institution, ga	ive street and number;	)			4b. City, Town, or	Location of Deeth	4c. County of D	eath
			Genesis Elder	care Sever	na Park				a Park		Arundel
	Funeral Director		5. Sociel Security Number 6. 153-10-8855	Sex 7. Ag 1 □ M <b>3</b> € F	ge (In yrs. lest bi		Inder 1 Year nths Days		. (Month, Da	th y, Year) 31,1917	Birthplace (State or Foreign Country) New York
	lend wo		Usuel Residence of Decedent  10a. Stete 10b. County		10c. City, Tov	vn or Location	n				10d. Inside City Limits
	Mary Figh	ঠ	Maryland Anne Ar	undo1	Sou	erna F	ark				1 □ Yes 2X No
	1 the	8	10e. Street end Number	didei	bev.		of. Zip Code			10g. Citizen of Whet	Country?
	th with	alD	24 Truck House	Road			2114	46		USA	
020	permit. Peges 1 end 2 should be filad within 72 hours after death with the Marylend Depertment of Health end Mantel Hygiena. Important: If Item 27 is merked other than "natural", or flems 23e or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Maritel Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give A Year or Dates:	No	1 U Y	′es 2∏No			14. Race - A Black, W Specify:	merican Indian, /hite, etc. White
21215-0020	/ithin 72 ho na. han *natul • Medical	Completed by	15. Decedent's Elementary/Secondery (0-12)	Educetion rede completed) College (1-4or	16e			petion during most of wo ad)	rking	16b. Kind of Busine	
	ygie ygie nt, th	S	12	-0		Home	maker	do bish site blo	one (Final Adiabate	Own Home	
Maryland	tel H d off	Be	17. Fether's Name (First, Middle, Las							Maiden Sumame)	
7	Man Man Man Man Man Man Man Man Man Man	ဥ	Norman John Senn		1				C. Scru		
Jai	2 sh end is m		19a. Informant's Name/Relationship				•			er, City or Town, Stat	
	1 end Health em 27		Michael N. Dunlo	p, Son	6.	30 Ame	ricana	a Drive A	nnapolis Date	Maryla  20c. Location - City	
O	ges tof H		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3	☐Removal from State	20b. Place o	ery, cremator	y or other pla				
Ë	man mant: jury		4 ☐ Donation → ☐ Other (Spec	sify)		Crema	tory ]	Inc.	12/01/04	Baltimore	, Maryland
Baltimore,	permit. Peg Depertment Important: I any injury o		21. Signature of Funeral Service Lice Thomas Gregor			Crem	ne and Address ation	Society	of Maryl	and Inc. re, Maryl	1 01000
1	Physician /Medical Examiner	4	23a. Part 1. Enter the disease, or conshock, or heart tailure. List online Immediate Cause (Final disease or condition resulting in death)	y one cause on each I	2 n C C  Due to (or as a	1 A	Izhe	uner.	A		Approximate Interval Between Onset and Death
68760, <	tificate be axecutêd ng physiclan end as the buriel-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Course (Disease of white)	b	Due to (or as a	consequenc	e of):				
Box 687	- U W	Physician/Medic	that initiated events resulting in death) Last	d	Due to (or as a	consequence	e of):				
E	a daa he at hed fo	왕	Part II. Other significant conditions	contributing to death b	out not resulting	in the underly	ing ceuse gi	ven in Part I.	23b. Did	tobecco use contrib	ute to the cause of death?
, P.O	iras that tha daath cer signed by the attandir d be datached for usa	by Phy		-					10	Yes 2□ No 3□	Probably 4 Unknown
Records,	law requiras as been sig 2 should b	Completed b								an autopsy 24 rmed?	Were eutopsy findings available prior to completion of ceuse of death?
Œ	The sta h								10	Yes 2UNo	1 ☐ Yes 2 ☐ No
Vital		Bec	25. Wes case referred to medical examiner?					26. Place of De	ath (Check only o	one)	
<b>&gt;</b>	3 5 5	2	1 Yes 2 No	Hospital: 1 Inpati	ent 2 ER/O	utpatient 3	□ DOA Ot	her: 4 [ Nursing I	Home 5 ☐ Resid	dence 6 □Other (S	Specify)
ion of	Attending Ph ir deeth. Sctor: After th by the funerel		27. Menner of Death 1 Natural 5 Pending 2 Accident investigati	28e. Date of Inju (Month, De	y Year) 28b.	Time of Injury M	28c. Inju Wo	iryet ork? ]Yes 2 ☐ No	28d. Describe I	now injury occurred	
Division	To the Hospital or Attending Phys within 24 hours aftar deeth.  To the Funeral Director: After this completely fillad in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not determine	A ZOO. Place of III	jury - At home, f c. (Specify)	arm, street, f	actory, office		28f. Location (S City or Tox		Rural Route Number,
	• Hospi 24 hou • Funer letely fill	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exs	hysician: To the best miner: On the basis of and manner st	f exemination er	e, death occu nd/or investig	urred at the ti ation, in my	ime, date and place opinion, death occi	e, and due to the urred at the time,	cause(s) and manner date and place, and o	r as stated. due to the cause(s)
	Withir To the	Me	29b. Signature end title of certifier				29c Licen	se number	6	29d. Date signed (Me	onth, Dey, Year)
				M	1.	(VI)	Di	007d		12-1-	2004
		, [	30. Name end address of person who	completed cause of a	death (Item 23e)	(Type, Print)	nsH	Wy M.	llersv	le M	D 21108
	Sta		31. Dete filed (Month, Day, Year)	2004 32. Registi	rar's Signature	19	Span	(s)		,	

			• •		artment of Health and N	•	•	
			For 1 = State Registrar		rtificate of Death		2004	38273
			Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
	Physici /Medio		Mary Helen Druckenbro	d		November	29, 2004	1945 M
	Examir		4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or Location of Death		4c. County of Death	
			Shady Grove Adventist Ho	<del>.</del>	Rockville    If Under 1 Year   If Under 24 Hrs.	0.00.40.45	Montgomer	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F	. Age (In yrs. last birthday,  86 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 1 January 17	Year) 9. Birthp	place (State or Foreign htry) nio
			Usual Residence of Decedent			January 17	, 1910 UI	.110
	arylan show	_	10a. State 10b. County	10c. City, Town or L	ocation		1	Od. Inside City Limits
	28e-f	Funeral Director	Maryland Montgomery	Rockvil				1 ☐ Yes 21€ No
	with the or 3	ä	10e. Street and Number		10f. Zip Code		g. Citizen of What Cour	
	ns 23	era	9921 Silver Brook Drive  11. Marital Status 12. Was Deced	lent Ever in U.S. 13.	20850 Was Decedent of Hispanic Origin? (Splf Yes, specify Cuban, Mexican, Puerto		United Stat	
9	or Ita	Fur	Armed Force  1 Never Married 2 Married 1 Yes, Give	2 € No		Rican, etc.)	Black, White,	etc.
21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland I Health and Mental Hyglene. I then the marked other then "naturel", or Itams 23e or 28e-1 show item 27 is marked other than "naturel", or Itams 23e or 28e-1 show other treumetic event. The Medical Examination and De notified at	d by	3 Widowed 4 Divorced Year or Da	es:			Specify: Whi	
15	n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ina	6b.Kind of Business/Ind Aircraft En	•
12	filed with! Hygiene. other than	шо	Elementary/Secondary (0-12) College (1-	4or 5+)	nic Artist/ Illust		Manufac	0
þ	other	Be C	17. Father's Name (First, Middle, Last)			e (First, Middle, Mi		Luling
/lar	uld by Wenta Wenta rrked	5	Ralph Arthur Barrett		Anne Bo	усе		
Maryland	2 should be 1 and Mental I is marked o reumetic eve		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or Rui			·
	item 27 i		Jennifer Campion/ Grando 20a. Method of Disposition	aughter 7018	Surrey Drive, Bal		aryland 212 Oc. Location - City or To	
Baltimore,	permit. Pages Department of I Importent: If ite any injury or of		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from S	late	matory or other place) Dece	mber 7,		
Ħ	permit. Page Department o Importent: If any injury or once.		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		Cemetery 200		leveland, (	Ohio Peral Home/
Ba	Depa Impo any ir		132	M01405 R	2. Name and Address of Facility Rob ockville, Inc. 300 ockville, Maryland	West Mo	ntgomery Av	zenue
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not en				Approximate Interval Between
	Pnysician			cordial inf	arction			Onset and Death
	/Medical Examiner		resulting in death)	r as a consequence of):				
		<u></u>	Sequentially list conditions, b. Due to (c	r as a consequence of):				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.	,				
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x 68	eath certificat attending phy I for use as the	Physician/Med	IF FEMALE:	ome of pregnancy				
Вох	attend for us	cian	in the past 12 months?	th 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
o.	that the de led by the a detached i	ysic	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown					
٥.	The law requires that the death certifica Ite has been signed by the attending ph tage 2 should be delached for use as th	by Pl	Part II. Other significant conditions contributing to dea	th but not resulting in the t	underlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
Records,	w require been sig should b	edt	anemia			1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
ecc	law re as be 2 sho	Completed				24a. Was an autopsy	24b. Were autop	osy findings available inpletion of cause of
= B		Con				performe	ed? death?	2/2 No
Vital	Phyeiclen: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?			h (Check only one)		
of	Phyer this ral di	1.10	1 Yes 2 No Propriation 27. Manger of eath 28a. Date of	patient 2 ER/Outpatie		rne 5 Residen 28d. Describe how	ce 6 Other (Specify	′)
O	th. : After s funer	tion		, Day Year) Injury	Work? M 1 □ Yes 2 □ No		many occarrod	
Division	f or Attendi after death. Director: A I in by the fu	ifica	3 Suicide 6 Could not be 28e. Place of	of Injury - At home, farm, st g, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rura	l Route Number,
	tel or rs afte el Dir ed in	Certification:	4 Homed	g, etc. (opecny)		City of Yown,	State)	
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edicai	(Check only 2 Medical Examiner: On the bas	sis of examination and/or in	th occurred at the time, date and place, ovestigation, in my opinion, death occur	and due to the cau	ise(s) and manner as st	ated. the cause(s)
	thin 2 the 1 the 1 mplet	Med	one) and manne 29b. Signature and title of certifier	er stated.	29c. License number		d. Date signed (Month, I	
	£ ₹ 8		A licia J. N	listry MI			Jovember	,
	in		30. Name and address of person who completed cause					
	1,0		Alicia T. Mistry	9901 M	Local Center	ROCKNI	lie, MD à	20850
	Sta			gistrar's Signature	/			
	Registr	ar	DEC 0 3 2004	forces to	Sparks			

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

O. Box 68760.

Division of Vital Records.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 1230A M Martin 24, 2004 EDWOODS Movember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Aug. 7, 19 Birthplace (State or Foreign Country) Funeral 1**∑** M 2□ F Months Days Hours Min. 78 Yrs. Director 1926 Baltimore, MD <u> 217–20–0983</u> Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other than "natural", or items 23a or 28a-f show othar traumatic evant, the Neulcal Examinar must by notified at 1 TYes 2 □ No Director Wheaton Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States 3802 Elby Court 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√D/Yes 2 □ No IKYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1□Yes 2□No Baltimore, Maryland 21215-0036 Specify: þ Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Entertainment Actor +2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Edelstein Emileia Edelstein-Aaron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Is m any injury or othar traum 2006. 3802 Elby Court Wheaton, MD 20906 David M. Edwards 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State Chesapeake Crematory 12/2/04 Beltsville, MD <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Rapp Funeral and Cremation Services 933 Gist Avenue, Silver Spring, MD 21. Signature of Fur eral Service Lice of ee 20910 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Lung carcinonea disease or condition resulting in death) /Medical Due to (of a a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ COPD 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 2 No 1 Yes 1 Yes the Hospital or Attanding Physician: hin 24 hours after death. the Funaral Diractor: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 2 D39793 200 D Nacy , Mis. Margueler 24, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christoplex J. Mays, M.B. 18111 Prince Philip De. Olnay, ms 20832 31. Date filed (Month, Day, Year) LEC 03 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 38276 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Illian Evans November 29-2004 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Roland Baltimore Park ano If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days 1 M 2 TF Yrs. 219-12-8183 **Director** Usual Residence of Decedent hours efter death with the Marylend 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "netural; or items 23e or 28a-f show treumatic event, the Medical Examiner must be notified at MD 1 Nes 2 No Baltimure Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 124 W. 10515 St. Franklin - Apt. 109 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify: Baltimore, Maryland 21215-0020 Specify: 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "netu 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housew, Fe 12 SEZF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arnetha Segens Burgers Evers Henry John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Franklin St. - Apt. 513, Baltimore Mozizer 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 → Burial 2 Cremation 3 Removal from State 12/8/04 OWINGS Mills, MO Garrison Forest V.A. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Service, P. A. Havi P. Cluse Funeral Service, P. A. 21. Signature of Funeral Service Licensee Hari Baltimore MD 21201-1925 709 Tessien 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Deeline Examiner Examiner the ettending physician end ched for use as the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hypertensis Physiclan/Medical that initiated events Due to (or as a consequence of): resulting in death) Last Forline Heart Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Discerse Joint \$ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 3 Line 1 ☐ Yes 2 ☐ No this certificete 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes \_2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred efter death. Diractor: After t 1 Natural Injury

Division of Vital Records, P.O. Box 68760, or Attending Physicien: 24 hours Hospital

5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

away

MD

D31464

04

SHO A113 A. HAS HMI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. Enlaw H Inte 305 Ball. MD 21201

Registrar

Medical

32. Registrar's Signature

To the within 2

		1 - For State Registrar	State of Maryland	04 TT  K Indelible Ink. Ensure  Department of Health and  Certificate of Death	ı wentar mygle		38277
		Registrar     Decedent's Name (First, Middle, I	ast)	Certificate of Death	Reg.	. No.	3. Time of Death
Physic		TOVOME	Edwants		Month De C	Day Year	250P
/Medi Exami		4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town, or Location of De	1	4c. County of Death	1
		FUTURECARE	HOHEWOOD	BALTIMOR	E		
Funeral Director	C	5. Social Security Number 6.	Sex. 7. Age (In yrs. last		in. 8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreintry)
yland how		Usual Residence of Decedent  10a. State 10b. County	11	own or Location			10d. Inside City Limi
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Mourel Ex., illustrout the multiple an	Funeral Director	MD N	A BALT	100 RE	10g.	. Citizen of What Cou	1 <b>∑</b> Yes 2 □ N intrv?
sath with	erai Di	1713 Appleton	Street	21217	/C	U.S.,	4.
s after dea , or Items	Fun	11. Marital Status  1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	14. Race - Amer Black, White	
al', or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: BL	ACK
"natural",	ted	15. Decedent's (Specify only highest of		6a. Decedent's Usual Occupation (Give kind of work done during most of v	16t	b. Kind of Business/Ir	ndustry
han "	Be Completed	Elementary/Secondary (0-12)	College (1,4or 5+)	life. DO NOT use retired)	volking	N/	4
iled v Hygie ther t	S	17. Father's Name (First, Middle, La	N/A	19 Mother's N	lame (First, Middle, Mai		
e d fa	To Be	Daniel Shower	ll	Willi	e Mae E	dmond	
s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)	9b. Mailing Address (Street and Number or	Rural Route Number, C.	ity or Town, State, Zi	Code)
1 and Healt em 2 ther		20a. Method of Disposition	= 20b. Place	of Disposition (Name of the )	Date UNIC 200	. Location - City or T	own State +++-JK
ages nt of t: If it		1 ☐ Burial 2 🙀 Cremation 3	Removal from State	etery, crematory or other place)			
artme ortani injury		' 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	A C			Baltimor	e, MD
permit. Pages 1 and 2 of Department of Health ar Important: If item 27 is any injury or other trauguce.		1 Vangh	C4	Name and Address of Facility Vaughn C. Greene F 515 Baltimore	Jaylona PII	ce Ballo.	MD 21229
			mplications that caused the death. D ly one cause on each line.	o not enter the mode of dying, such as card	iac or respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Gastantestina				Onsor and Doam
Examiner		· · ·	Due to (or as a consequence	e of):			
- 11	e	Sequentially list conditions, if any, leading to immediate	b. Duaderal ula  Due to (or as a consequence				
executed in and ial-transit	xamin	cause. Enter Underlying Cause (Disease or injury that initiated events	c. Anemia				
an an rial-tr	ш	resulting in death) Last	Due to (or as a consequence	:e of):			
cate be ex physician s the burial	icai	,	d				
rtifica ng ph i as th	Med	IF FEMALE:					
law requires that the death certificate be eas been signed by the attending physiciar 2 should be detached for use as the buri	by Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown			23d. Date of deliv Month	өгу Day Year
res martigned by	y Ph	Part II, Other significant conditions	contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
sign sign	Q p	END STAGE G	Pened Discusc		1 ☐ Yes	2 □ No 3 □ Prol	ably 4 Unkno
s been si	Completed	Deal store to	11114		24a. Was an	24b. Were auto	psy findings availa
D = 0	шо	<u> </u>			autopsy performed 1 ☐ Yes 2 ☑	death?	mpletion of cause
certificate rector, pag	O	25. Was case referred to medical		26. Place of E	Peath (Check only one)	NO ILLITOS	2   140
	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/		Home 5 Residence	e 6 Other (Special	(y)
nysician: ils certifica director,	:uo	27. Manner of Death 1 DNatural 5 □ Pending		D. Time of 28c. Injury at Work?	28d. Describe how i	njury occurred	
ng rnys fter this ineral dii		2 Accident investigat 3 Suicide 6 Could not	ho	M 1 ☐ Yes 2 ☐ No			
ng Phys fter this ineral dii	cati		28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
ng Phys fter this ineral dii	Certificati	4 Homicide determine			and due to the cours	e(s) and manner as s	tated
ng Phys fter this ineral dii	edical Certification;	4 Homicide determine	Physicien: To the best of my knowled aminer: On the basis of examination and manner stated.	dge, death occurred at the time, date and pla and/or investigation, in my opinion, death oc	curred at the time, date	and place, and due to	the cause(s)
To the Hospital or Attending Physic within 24 hours after death.  To the Funeral Director: After this ce completely filled in by the funeral director.	Medical Certificati	4 Homicide determine  29a. Certifier 1 Certifying I (Check only 2 Medicel Ex	aminer: On the basis of examination :	dge, death occurred at the time, date and pla and/or investigation, in my opinion, death oc 29c. License number	curred at the time, date	and place, and due to Date signed (Month,	the cause(s)
ng Phys fter this ineral dii	Medical Certificati	4 Homicide determine  29a. Certifier (Check only one)  29 Medicel Ex	aminer: On the basis of examination and manner stated.	and/or investigation, in my opinion, death oc	curred at the time, date	and place, and due to	the cause(s)
ng Phys fter this ineral dii	Medical Certificati	4 Homicide determine  29a. Certifier (Check only one)  29b. Signature and title of certifier	aminer: On the basis of examination :	29c. License number  Doc. 590 56	curred at the time, date	and place, and due to Date signed (Month,	o the cause(s)

			1- State of Maryland / Department / Department	artment of Health and M rtificate of Death			38278
		3-1	1. Decedent's Name (First, Middle, Last)	Tuncate of Death	Reg.	Nd 0 0 -4	3. Time of Death
П	Physici	an	LARRY SIMON ERBY		Month	Day Year	A4
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	November :	30 2004 4c. County of Death	1:10 a "
	LAQIIIII	-	4124 GRAVEL HILL ROAD	HAVRE DE GRACE		HARFORD	CO
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9 Birthol	ace (State or Foreign
ū	Director		218-54-0404 1X M 2□ F 53 Yrs.	World's Days Hours Will.	DEC. 28	1950 WEST	VIRGINIA
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		10	Od. Inside City Limits
	Maryi f sho	ro		RE DE GRACE		i i	1 ☐ Yes 2 🔀 No
	the 28e	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	try?
	h with		4124 GRAVEL HILL ROAD	21078		U.S.A.	
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - America Black, White, e	
98	or ite		1 Never Married 2 Married 1 XX es 2 No	1 ☐ Yes 2KKNo Specify:	, noarr, otc. /		
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or items 23s or 28e-f show evant. The Medical Examinating in Items 18.	d by	3 Wildowed 44 Divorced Year or Dates: / U / / 4		1	Specify: BLAC	
5	in 72	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workii DO NOT use retired)	ng 160	. Kind of Business/Ind	ustry
212	with jene. r ther	шо	Elementary/Secondary (0-12) College (1-4or 5+)	RVISOR MAINTENCE		CIVIL SERV	ICE
	e filec Il Hyg othe	e e	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	den Sumame)	
lar	uld be Venta Irked tic ev	To B	CURTIS ERBY	DORIS I	ERBY		
Maryland	2 sho and 1 Is ma		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Mailin	ng Address (Street and Number or Rura	l Route Number, Ci	ty or Town, State, Zip	Code)
	and ealth m 27 her tr			Gravel Hill Rd., I			
Ore	ges 1 t of H If Ita or ot		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  Commetery, creft	natory or other place)	ate 20c	Location - City or Tov	wn, State
Baltimore,	t. Partmen rtant: njury		#	IEM. GARDENS   12-06	5-04 Al	BERDEEN, M	ARYLAND
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then "natural", or items 23s or 28e-f show any injury or other traumetic event, the Medical Exeminal must be notified at once.		WM	2. Name and Address of Facility I C BROWN COMMUNITY			
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent	21 S PHILADELPHIA  er the mode of dving, such as cardiac o	BLVD., Al		Approximate
	11.7		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Cartinyac	1	Q	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):	e come of the	iac e	- Rese	
	Examiner		Sequentially list conditions b. HYPERTE	e Cardieves an			
	/ p ==	ner	if any, leading to infriedrate Due to (of as a consequence of).	4 6			
/1	ecute and trans	Examiner	that mitatod ovolko	1DEMIA			
,0928	ficate be executed physician and s the burial-transit	E E	resulting in death) Last Due to (or as a consequence of):				
387	physicate sthe	dical	d				
×	death certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliver	v
.O. Box	death e atte d for	icla	in the past 12 months?  1 Yes 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)			Day Year
P.0	t the by the tache	hys	9 Unknown				
Ś	The law requires that the death certifi tte has been signed by the attending bage 2 should be detached for use as	ру Р	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		to use contribute to the	
ord	w requir been si should				1 ☐ Yes	2 No 3 Proba	bly 4 Unknown
Vital Record	e law r has be	Completed			24a. Was an autopsy	prior to com	sy findings available
<u> </u>		Con			performed	? death? No 1 ☐ Yes 2	2□ No
Zii	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death Other: 4 A Nursing Hon	4.7.5		
	Phys r this ral di	. To	1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatien  27. Manner of Death 28a. Date of Injury 28b. Time of	4 Nursing Hon	ne 5 X Pesidence 8d. Describe how in	6 Other (Specify)	
Division of	iding Ph th. : After th funeral	tlon	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		ijary occurred	
VISI	Atter or dea ector by the	ertification:	3 Suicide 6 Could not be	eet, factory, office	8f. Location (Street	and Number or Rural	Route Number,
Ö	tel or rs afte al Dir	Cert	4 Homicide building, etc. (Specify)		City or Town, St	are)	
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause ad at the time, date a	o(s) and manner as sta and place, and due to	ited. the cause(s)
	To the within 2 To the complet	Me	29h. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, D	Pay, Year)
)			I ligary & Tellere in	021119		1/30/04	
	1011		30. Name and address of person who completed cause of death (Item 23a) (Type, VITAY K. NELLORE, V	Print) IAMIC, PERR	x Poin	7, MD 2	1902
100	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 3 2004  32. Refistrar's Signature	horse			

State of Maryland / Department of Health and Mental Hygierie O. O. I.

		•	For State Registrar	ite of Maryland	Cer	tificate o	f Death	ina mentan n	Reg. No.	14 38215	1
	Physici /Medio		Decedent's Name (First, Middle, Last)     CALMEN			ESCH	ter.	2. Date of D Month NVBM	bor Day 26	Year 2004 3. Time of Death	M
	Examin		201110	BAYVIEW		4b. City, Town	TIMOY	E CTY		N/A	_
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2  Usual Residence of Decedent	7. Age (In yrs. las 96	Yrs.	If Under 1 Year Months Day		Min. (Month, D	5,1908	9. Birthplace (State or Fore Country) Puerto Rico	ign 
	Maryland e-f show	ctor	10a. State 10b. County  Maryland Baltimo		Town or Loc	cation	Dun	dalk		10d. Inside City Limi 1 ☐ Yes ����	
	be filed within 72 hours after death with the Maryland that Hygiene.  od other than "natural", or Items 23e or 28e-1 show of other than "natural", or Items 23e or 28e-1 show event, it is Medical Exam incrinial te modified at	eral Director	10e. Street and Number  6903 Broening Road  11. Marital Status 12. Wa	s Decedent Ever in U.S.	13. V	10f. Zip Code	2122			What Country?  d States  e - American Indian,	
9800	ours after d rral', or Item Examinat	by Funeral	1 Never Married 2 Married 1 If N	ned Forces?  Yes 2 XNo es, Give ar or Dates:	1	Yes, specify Ci		in? (Specify Yes or N Puerto Rican, etc.) Puerto Ric		ck, White, etc.	
Maryland 21215-0036	filed within 72 h Hygiene. Ither than "natu int, the Medical	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Co 8 Years		(Give I life. D	lent's Usual Occ kind of work dor DO NOT use reti Ctory Wo	e during most red)	of working		usiness/Industry nufacturing	
rland 2		To Be Co	17. Father's Name (First, Middle, Last) Benigno Viera					r's Name <i>(First, Middle</i> guelina Pe		тө)	
	nd 2 shouth and 27 is m		, , ,	ghter	400	Wise Av		r or Rural Route Numb ndalk, Mar	yland 2	21222	
Baltimore,	Page: nent o ant: If ury or		20a. Method of Disposition  1   □ Burial 2 □ Cremation 3 □ Remove  1 □ Donation 5 □ Other (Specify)	I from State	etery, crem Lawn	sition (Name of natory or other p Cemeter	y 11/	Date 30/2004	Baltimo	ore, Maryland	
Bal	permit. Par Departmen Importent: any Injury once.		21. Signature of Funeral Service Licensee		7	922 Wis	e Ave.	<u>.</u>	Marylan	d 21222	
,	Pnysician /Medical		23a Part1. Enter the disease, or complication shock, or heart takere. List only one cause immediate Cause (Final disease or condition resulting in death)	s that caused the death. se on each line.  Oue to (or as a consequer	HMI	A mode or d	ying, such as o	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death	:5
	Examiner	Jer	Sequentially list conditions, is any, leading to fine dilate cause. Enter Underlying Cause (Disease or injury			NEUM	WRE	and desired	1	Herns	
\±',09Z89	rtificate be executed ng physician and as the burial-transit	cal Examiner	that initiated events c.	ASPINATION Due to (or as a consequer		NEVM	יודינאט.	SICATION APPRO D B	MEDIC.	Hours	>
89 x	n certificate I	/Medical	IF FEMALE: 23c. If y	es, outcome of pregnance	y					te of delivery	
.O. Box	death e atte	Physician/	in the past 12 months?	Live birth 2 Fetal de Pregnant at time of deat Unknown	eath 3 🗌	Ectopic pregnar Other (specify)	су			onth Day Year	
rds, P	The law requires that the de ite has been signed by the a bage 2 should be detached	by	Part II. Other significant conditions contributions			1 -	given in Part I.	23e. Did	tobacco use cont	nbute to the cause of death?  3 Probably 4 Unknow	₩n
Vital Records,		Completed	HIP FRACTURE					24a. Wa: auto perf 1 □ Yes	opsy ormed?	Were autopsy findings availab prior to completion of cause of death? 1 □ Yes 2 □ No	ole if
Vita	sicien: certific rector,	o Be (	25. Was case referred to medical examiner?  1 Yes 2 No  Hospita	l: 1 Inpatient 2 EP	2/Outpotion	t 3 DOA	ther	of Death (Check only	one)		
n of		$\vdash$			Bb. Time of Injury	28c. In			how injury occur	red	
Division	tent death tor: the	Certification:	2 Accident investigation	EMBER 2 2w4 . Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, offic	⊒Yes 2 <b>2</b> e	28f. Location City or To	wn, State)	er or Rural Route Number,	_
1	dospite t hours unsrel	edical Ce	29a. Certifier (Check only one) (Check only one)	To the best of my knowle the basis of examination d manner stated.	edge, death	occurred at the	time, date and	place, and due to the	ENING ROW cause(s) and ma date and place,	inner as stated.	12
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signe	d (Month, Day, Year)	

29b. Signature and title of certifier

70448

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVBUE BATIMONE SUSAN GERLHARDT, 31. Date filed (Month, Day, Year)

State Registrar

DEC 0 3 2004

32. Registrar's Signature

DHMH 17 Rev 1/2001

Amend item#26, perMD, G838/12/03/04 TT State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year LIFTON NOV 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4037 LARKSPRING ROW HOWARD ELLICOTT CIT 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Funeral 6. Sex Birthplace (State or Foreign Country) 518.16.7457 1 MM 2 ☐ F 85 Yrs. Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County s 23e or 28a-f show MD HOWARD Completed by Funeral Director 1 ☐ Yes 2 KUNo ELLICOTT CITY 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5218 HESPERUS DRIVE 21042 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 IX Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 250 Married 1 ☐ Yes 2 🗷 No Specify: Specify: PJACK 3 ☐ Widowed 4 ☐ Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other then Elementary/Secondary (0-12) College (1-4or 5+) EEOC EMPLOYMENT OFFICER 12th arade Wear 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fill and Mental H Be LINWOOD FELTON EDNA RICHARDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER If of Health PAMELA REDMON 4037 LARYSTRING ROW ELLICOTT CITY MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 DBurial 2 □ Cremation 3 □ Removal from State ö Department or Important: If eny injury or 12.01.04 SUITLAND, MD LINCOLN MEMORIAL \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICES 21. Signature of Funeral Service Licens ang SISI BALTIMORE NATIL PIKE BALTIMORE MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) blidde Conce **Physician** melostatio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check onl. one examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home | Specify Sister's 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred House After Injury Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 0 (1 30. Name and address of person work completed cause of death (Item 23a) (Type, Print) 32. Registra's Signature & Sworth 3 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. UUL 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 PM **Physician** 2004 Nov /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HIGH POINT PARKUITLE RD BALTIMERE If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 M 2 F Months Hours Min 84 201-10-8755 Yrs. Director ITALL Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Haath and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-1 ehow ury or other traumatic avant, The Mcdical Examinar mast be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director MD BALTIMORE pakville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HIGHPOINT RD 7917 21234 U.S. A 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Amarried U.5 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify. If Yes, Give Year or Dates: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White NAVY 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 13-4-NIA CONTRACTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ANT ONIC IORINI ANTONETTE VIGLIANI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AROLE Bolto. NO 21234 IORINI 7907 HIGH POINT RD-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pagas Department of Important: If it any injury or o → Burial 2 Cremation 3 Removal from State 12/1/04 Gardens oF Frith Bolto MS \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STella Funeral Home CHTD 21. Signature of Funeral Service Licensee HARTIEY MillER RO. BOITO 10 21034 harford Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the cauthors of the caut Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate ba executed anding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Cay 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ğ sate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 ... No 20 1 Yes Yes 25. Was case referred to 26. Place of Death (Check only offe, examiner' Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After th funeral 28a. Date of Injury (Month, Day Year) 27. Manny of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury within 24 hours after death.

To the Funeral Diractor; All completely filled in by the fu 1 Yes 2 No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number

Registrar

State

John C

31. Date filled Month, Day, Year)
DEC 0 3 2004

Downs

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32. Registrar's Sign were

ess of person who completed cause of death (Item 23a) (Type, Print) Maryland Oncology Touson

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#302

Towson

		1- State of Maryland Ragistrar Unpend Item 23a&27 per me	840° Ce	tificate of	Health and N as Death	lental Hy	gienez 0 ( Rag. No.	04 38282
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Examin		4a. Facility Name (If not institution, give street and number) 939 CREEK PARK ROAD		4b. City, Town, BEL AIR	or Location of Death	1101111	4c. County of	of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 ■ M 2 ★ F 20	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bird (Month, Da July 1	th Year) 984	9. Birthplace (State or Foreign Country) Maryland
yland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Lo	cation				10d. Inside City Limits
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036 ours after des rai', or Itams	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes, Give Year or Dates:		Was Decedent of fixes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black	- American Indian, , White, etc. white
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland t Health and Mental Hygiene. t Health and Mental Hygiene. t Ham 27 is marked other than "natural; or Itans 23e or 28e-f show other traumatic event, the Medical Exerciter must be rediffed at	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	dent's Usual Occu kind of work done DO NOT use retire ime stud	during most of work ad)	ing	dependent (studen	ent
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Maryla 12 should in and Men 7 is marke					t and Number or Run			
or Health of Health of Health of Health of Itam 27 I		20a. Method of Disposition 20b. Place	of Dispo	Creek Pa sition (Name of natory or other pla	rk Road, I	Bel Air,		014 City or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Important: If item; any injury or othar once.		'4 □ Donation 5 □ Other (Specify)  Bayv	iew	Cremator	y 11/29		Baltimo	
Bal permit Depar Impor any in		21. Signature of Funeral Service Licensee	22		ess of Facility ek Funeral			
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/Medical Examiner		resulting in death)  Due to (or as a consequence)	ce of):					
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38760, icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last C Due to (or as a consequence d	ce of):					
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To the Hospital or within 24 hours afte To the Funeral Direction completely filled in b	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled call Examiner: On the basis of examination and manner stated.	ige, death and/or inv	occurred at the ti restigation, in my	me, date and place, opinion, death occurr	and due to the o	cause(s) and mandate and place, ar	ner as stated. d due to the cause(s)
To the within 2 To tha complet	₹	29b. Signature and title of certifier  Mayurte Me Youl	w	29c. Licens	se number OCME		_	(Month, Day, Year) 26, 2004
		30. Name and address of person who completed cause of death (Item 23) ANAMY OREW 111	PEN		, BALTIMO	RE, MAR	YLAND 21	201
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			for State Registrar	State	of Ma	ıryland /		artment o		ealth and N Death	Mental Hy	/gier Reg. N	$Z \coprod \coprod$	L	38283
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Division of Vital Records, P.O.	Attending Physician: The law requires that the death certific death in death in death in death. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Ph	Part II. Other significant conditi	ons contributing t	o death but	t not resulting	in the un	darlving caus	e diver	n in Part I	23e. Did t	obacco	use contrib	ute to the	cause of death?
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			30. Name and address of person		ause of dea	ath (Item 23a)	(Type P			01177	1				-
	641		Jason Blac	K 660	01 /	Marth C				Towson	MO.	212	04		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 38284 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARY FRETER Year **Physician** Month 4:55 PM WILMA November 30 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County ol Death Examiner NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, Year, 12/05/1938 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🗓 F 65 212-36-8565 Yrs Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10h Count 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Expedient must be nutilied all 1 ☐ Yes 2X No Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Margaret Avenue 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Informatist If item 27 is marked other than "natural", or item any injury or other traumatic event, if we Medical Exertified ODGs. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 (XDivorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname William A. Welnosky Ethel (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Toni Freter / Daughter 1012 Upton Road Glen Burnie, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Cremation 12/03/2004 Stevensville, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave. SW, Glen Burnie, MD MO1415 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CEREBROVASCULAR ACCIDENT 4 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ate has been si page 2 should a 24b. Were autopsy lindings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death Check onl one examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Matural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place ol Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records.

Registrar

31. Date filed (Month, Day, Year)
THE 0.3 2004

Matthew Jack, mb

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

305 HOSPITAL DR. STE, 305, GLEN BURNIE, MD 2106 22. Registrar's Signature

29d. Date signed (Month, Day, Year)

November 30, 2004

(Check only one)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D47575

		í	For Amen State Registrar	d Items	State of 23aPtI,	of Mary PtII 1	land / Doper Dr	epa Cen	rimen lificate	2/01/H 2/01/ e of L	ealth a 3/04d Death	and Mah	ental Hy	giene Reg. No	004	382	285
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nd	be file tal Hyg d othe event,	Be	17. Father's Name Everett										(First, Middle E. Pa		Sumame)		
ıryla		ဦ	19a. Informant's N				19b. M	Mailing	Address	(Street a					or Town, State,	Zip Code)	
	5 # 12 # 2		Melvin F												A 34685		
Baltimore,	permit. Pages 1 at Department of Hea Importent: if item any injury or othe once.		20a. Method of Dis 1 Burial 2 1 Donation	□ Cremation	3 □Removal from	State C	Ob. Place of E cemetery, DakLawr	Dispos , crem 1 Ce	ition (Nam atory or or emete	ne of ther plac <b>: r</b> y	9)		ate 2/2004		cation - City of timore	r Town, State	
Balt	permit. Departi Import any inj		21. Signature of Fu	uneral Service	Licensee	t	-				s of Facili	<sup>by</sup> Cva e Bal	ch/Ros timore	edal MD	e Funer 21237	al Ho	me
			shock, or hea	art failure. List	complications that only one cause on	caused the each line.	death. Do no					cardiac or	respiratory a	rrest,		Approxir Interval Onset a	mate Between nd Death
	Physician /Medical		Immediate Cause disease or condition resulting in death)	on	a Due to	(or as a co	2	10	57				120			5 m	
	Examiner		Sequentially list co	onditions	b. #	10	/		lermi	naı	ASPI	ratio	<u></u>			15 m	ıın.
	ted	Examiner	Sequentially list contains to make the cause (Disease or	nmadiata erlying = injury	Duffe to	(ir as a co	nsequence of			,							
o,	icate be executed physician and s the burial-transit		that initiated events resulting in death)	S	c	(or as a co	nsequence of	):									
8760,	cate be ohysici the bu	edical			d												<u> </u>
.O. Box 6	ne death certif the attending thed for use a:	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1  Yes 2( 9  Unknown	! months? □ No		birth 2 🗀	Fetal death		Ectopic pro Other (sp		<del></del>				23d. Date of de Month	livery Day	Year
<u>α</u>	es lhat thighed by	by Ph			ons contributing to	death but no	ot resulting in t	the un	derlying ca	ause give	en in Part I		23e. Did t	tobacco	use contribute t		
ord	w require been sig should t		ALITA	I FIDE	ilation									Yes 2	□No 3□P	robably 4	Honknown
al Records,		Completed											24a. Was auto perfo 1 \( \text{Yes}		death?	utopsy findin completion of s 2 No	gs available of cause of
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case reference examiner?	/	Managani	Inpatient	2 ☐ ER/Outp	ationt	3 🗀 DO	Othe	ar.		(Check only o		6 □Other (Spe	noifu)	
n of	<b>ਦ</b> ⊨ <u>ख</u>	$\vdash$	27. Manner of Dear		28a. Date		28b. Tir	ne of		8c. Injury Work	at		8d. Describe			ony)	
Division	Attending ir death. ector: After by the fune	catic	2 Accident	investi	gation				M		Yes 2□		Rf Location (	Stroot ar	nd Number or R	tural Pouto A	lumbar.
Div	Dir.	Certification;	4 🗍 Homicide	determ		ding, etc. (S	At home, fam pecify)	11, 5110	ei, iaciory	, onice		1	City or To			urar noble n	diliber,
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Physicien: To th Exeminer: On the l and mar	e best of m basis of exa nner stated.	y knowledge, imination and/	death or inve	occurred a	at the tim	ne, date an pinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s)	and manner a d place, and du	s stated. e to the caus	e(s)
	To the vithin To the comple	M	29b. Signature and	title of certifie	1	//			29c	. License	number			29d. Da	te signed (Mon.	th, Day, Yea	r)
			30. Name and add	21165	who completed cau	21	(ltom 22a) /7	VPO F	Print'	020	24/2	7		-//	1.19.0	9	
	30		JO. Name and add	MS	E- a	2//	2 2	6/6	2 (a.	101	11 A	1.	Taken	na s	012, 1	14.7	2/12
	Sta		31. Date filed (Mor	nth, Day, Year)	32.	Registrar's	Signature		1								
#	Registr	ar	DEC	0 3 200	14 Ben	mar	19	1	DOUN.	21							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar AMEND TTE	State of Maryland /	Depa 1 <b>9</b> %	rtment of H iticate	ealth and	Mental Hygid <b>/08/04</b> JI	ene 1. 2001	38286
	Physici /Medic		1. Decedent's Name (First, Middle, Last)			,	iers	2. Date of Death Month	Day Year	3. Time of Death
)	Examin	er	4a, Facility Name If not institution, give s  1	ive Hospins	birthday)	4b. City, Town, or	Location of De	ath  / /  rs. 8. Date of Birth	4c. County of Dea	th thplace (State or Foreign
	Funeral Director			JM 2□F 46	Yrs.	Months Days	Hours Mi	n. (Month, Day, ) Dec 19,	rear) C	JERSEY
	how		10a. State 10b. County MD	10c. City, To						10d. Inside City Limits
	the Ma 28a-1 s	Director	10e. Street and Number	Ба	1tim	10f. Zip Code		100	g. Citizen of What C	1¼ Yes 2 No
	3a or		6116 Belair Road			701. 219 0000	21206	,,,,	USA	ountry.
36	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show blood Examinational be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	ıkl	/as Decedent of Hi Yes, specify Cubar ☐ Yes 2X No	spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036		Completed I	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 16 completed) College (1-4or 5+)	(Give k life. D	ent's Usual Occupa ind of work done of O NOT use retired,	luring most of w	orking	6b. Kind of Business	<b>GIII</b>
nd 2	be filed within tal Hygiene. d other than event, If a Ma	Be Co	17. Father's Name (First, Middle, Last)	9-k 0 I	ORYW	ALL HAN		ame (First, Middle, Ma	CONSTRUC niden Sumame)	unk
aryla	2 should be and Mental is marked or raumatic ever	P.	JOSEPH RAY FLO  19a. Informant's Name/Relationship (Ty WILLIAM, FLOWER		9b. Mailing	Address (Street a	nd Number or	Rural Route Number, (	City or Town, State,	Zip Code)
	D = 1 = 0		20a. Method of Disposition  1 Burial 2 Cremation 3 R	20b. Place ceme	of Dispos	N. Wolfe ition (Name of atory or other place	50 1 50	Baltimore Date 20	MD 2123 Oc. Location - City or	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		4 □ Donation 5 ☑ Other (Specify)  21. Signatur of Funeral ryice License		St Ba	Name and Addres ate Anato Itimore,	s of Facility Omy Boa MD 21	rd 655 W. 1	Baltimore	Street
	Physician /Medical		23a. Rart1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Due cause on each line.	o not ente				t,	Approximate Interval Between Onset and Death / WEEK
	Examiner Du Lunsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events	Due to (or as a consequence:						
8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequence	ce of):					
.O. Box 6	ne death certif the attending thed for use a:	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Δ.	w requires that the bean signed by should be detact	by	Part II. Other significant conditions con	ntributing to death but not resulting	g in the un	derlying cause give	on in Part I.	23e. Did toba 1 ☐ Yes	V	o the cause of death?
al Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of 2 No
Vital	S S F	o Be	25. Was case referred to medical examiner?  1  Yes No	lospital: XInpatient 2 ER/	Outpatient	3□ DOA Othe	e.	eath <i>(Check only one)</i> Home 5 Residen	ce 6 □Other (Spe	acify)
ion of	ding TAfter fune	atlon: T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation		Time of Injury	28c. Injury Work M 1 🗆 Y	at	28d. Describe how		
Division	al or Attanos s after death if Director; id in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (	(Check only 2 Medical Evami)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	and/or invi	actination in my an	inion death oc	curred at the time, date	and place, and due	a to the causa(e)
	To the within 2 To the complet	Me	29b. Signature and little of certifies /  Pert K. M. 55ch  30. Name and address of person who co  Kent R. Nilsson  31. Date filed (Month, Day, Year)  DEC 0 3 2004	N TO MI	)	29c. License	number	290	I. Date signed (Mon	th, Day, Year)
•			30. Name and address of person who co	ompleted cause of death (Item 23a	a) (Type, P	Print)	, ,,,,,	1000	OVEMBER	1 2004
			Kent R. Nilsson  31. Date filed (Month. Day Year)	JR Johns Hop	okins	600 No	rth Wol	le Street	Baltimore	Maryland
	Sta Registi		DEC 0 3 2004	Bene a B	Rose	orkal				

			State of Ma		artment of He		-	_	
			1 - State Registrar		rtificate of D			No. 2004	38287
	g		Decedent's Name (First, Middle, Last)		~		2. Date of Death		3. Time of Death
	Physici /Medio		HELEN	6	AITHE	K	Month	Day Year	1 1255 AM
	Examir		4a. Facility Name (If not institution, give street and number)	):0	4b. City, Town, or	Location of Death		4c. County of Dea	
			505 CNOLFI ROL	e (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	BALTI	
	Funeral Director		5. Social Security Number 6. Sex 7. Ag	Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ar) 9. 617	thplace (State or Foreign
	ਹੁ		Usual Residence of Decedent	1.0			1 0 13;1	140	0 3.11
		Funeral Director	10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits 1 LYes 2 □ No
			Md. BATG.Co.	LIKE	SVIIIE		1		
			10e. Street and Number		10f. Zip Code	03	10g.	Citizen of What Co	ountry?
		era	11. Marital Status  12. Was Decedent Armed Forces?	ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spec	cify Yes or No-	14. Race - Ame	erican Indian,
9	or Iter	표	1 Never Married 2 Married 1 Yes 2 1	No			lican, etc.)	Black, White	te, etc.
93	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene.  Importent: If item 27 is marked other than "neturel; or items 23a or 28e-f show any injury or other treumatic event. It is Modified at one in injury or other treumatic event. It is Modified at one in the modified at one	d by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ Mo	Specify:		Specify: \3	LHCK
21215-0036		Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupa e kind of work done du DO NOT use retired)	tion uring most of workin	g 16b	. Kind of Business	/Industry
12		шc	Elementary/Secondary (0-12) College (1-4or 5		RGICAL	TEC	H	MEDIC	AL
d 2		Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name			
ılar		To B	ELVETT COWAN			Zope	THER	TURN	ER
Maryland			19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street a	nd Number or Rural	Route Number Cit	ty or Town, State,	Zip Code)
			ELLEN LECATO	50°	J Enois	Kd. F	KESVIIII	-11A.	71308
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 [FCremation 3 ☐ Removal from State	1	ematory or other place			. Location - City or BALT IM	
≣		l i	' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funda Service Licenses	METRO	22. Name and Address	RY DEC		FUNERE	
Ba			21. Signature of Full Property Control Liberty Control Property Control Pr		Lizz L	herty 1	date D	I DIVOK	al Home
	eath certificate be executed  Wedical  Wedical  In use as the burial-transit  To use as the burial-transit		23a. Part1. Enerthe disease, or complications that caused shock, or heart failure. List only one cause on each lie	the death. Do not er	nter the mode of dying	, such as cardiac or	respiratory arrest,	IVL.	Approximate
		22 1	Immediate Cause (Final disease or condition	0. A-1 CI	Maridow	1.A			Interval Between Onset and Death
			resulting in death)	a consequence of):	Ince in the				10014143
			Sequentially list conditions, b. GAGT	2CINOW	+			WEEKS	
		Examiner	Sequentially list conditions, in any, leading to him oblistic cause. Enter Underlying Cause (Disease or injury that initiated events  c.						
		хап	c. Due to (or as a consequence of):						· · · · · · · · · · · · · · · · · · ·
760,	e be e sicien e buris	caiE	d						
9	tificating phy as the		·						
Box	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phyto the Funerel Director. After this certificate has been signed by the attending phyto completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth		□Ectopic pregnancy			23d. Date of delivery	
		sicia	in the past 12 months?  1 □ Yes 2 ☑ No  4 □ Pregnant at		Other (specify)	Month Day Year		Day Year	
P.0			9 Unknowh 9 Unkn					acco use contribute to the cause of death?	
ds,		d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  ANEMi'A			THE COLUMN	1 ☐ Yes 2 ☒No 3 ☐ Probably 4 ☐ Unknown		
Records,		Completed					24a. Was an	24h Were au	utopsy findings available
Re		E C					autopsy performed	prior to death?	completion of cause of
of Vital		O	1						
		To B	examiner? 1 Yes 2 No Hospital: 1 Inpatie	nt 2 ER/Outpatie	ont 3 DOA Other	T: 4 ☐ Nursing Hom	e 5 K Residence	6 Other (Spe	cify)
		Certification:	27. Manner of Death  ↑SC Natural 5 □ Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?				28d. Describe how injury occurred		
			2 Accident investigation	444	M 1 Yes 2 No		COM Landing (Charles of Name Lands)		
ΟĬ			4 Homicide determined 28e. Place of Injury - At nom building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
			29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
		edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	To the To the Comp	Me	29b. Signature and title of certifier		29c. License		29d.	Date signed (Mont	h, Day, Year)
			Kuuli Elels		U34	827	/2	13/04	
	3		30. Name and address of person who cap pleted cause of d	eath (Item 23a) (Type	Print)	ur alim	101 To.	100	N 0 1== :
	- CA	10	JAMES ESELING, MD 7401 OSCEL DRIVE SUITE 101 TOWSON, MD 21204  1. Date filed (Month, Day, Year)  1. 32. Registrar's Signature						
* à	Sta Registi		DEC 0 3 2004	k 1	R.				
		T. T.	T LOUT PROPERTY	A. 18034					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene \( \begin{align\*} \infty & \limits & 38288 For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav **Physician** Patricia Ann Gardner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner If Under Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Min. Days Months Hours 1 M 2 F 212-36-5574 Director Pennsylvania June 15.1938 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumetic event, the Medical Exarciner must be notified at 1 Tyes 2 XNo Director Middle River Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21220 United States Items 23a 401 Bowleys Quarters Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married ☐Yes 2 Yes, Give 2 No Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: and Mental Hygiene. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mildred Todero John Marsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is eny injury or other tre <u>once.</u> Mr. William Gardner / Husband 401 Bowleys Quarters Road Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 11/29/2004 Rosedale, MD permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dundalk, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed chemic Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 XYes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient ဥ 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 XNatural 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 | Homicide Fo the Hospitel within 24 hours a To the Funerel I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 03 Registrar

DHMH 17 Rev 1/2001

Patricia

ORIGINAL

		1 - For State Registrar	State	of Man	yland / D	epartr <i>Certifi</i>	ment of H icate of I	lealth Deai	n and M th	lental Hy	/gien	2004	38289
Physicia		1. Decedent's Name (First, Middle, L Hilda		raben	stein					2. Date of D Month	Da	ay Year 30,200	
/Medic Examin		4a. Fecility Name (If not institution, g Saint Joseph			Center		. City, Town, or	Location	on of Death	on	40	County of Dea	
Funeral Director		5. Social Security Number 6. 218-30-5296	Sex 1☐M 2∏F	7. Age (/	n yrs. last birt. 92		Under 1 Year onths Days	If Und Hour	der 24 Hrs. 's Min.	8. Date of B (Month, D October	irth Pay Year 9, 1	) (	rthplace (State or Foreign country) aryland
aryland show	7	Usuel Residence of Decedent  10a. State 10b. County  Maryland N/A		10	0c. City, Town	or Location	on						10d. Inside City Limits 1 ☑ Yes 2 □ No
r 28e-f	Director	Maryland N/A			Dail		Of. Zip Code				10g. C	itizen of What C	ountry?
th with	al D	6101 Sefton Aven	ue				21214					USA	
or for the many familiar of the force of the death with the Maryland ges 1 and 2 should be filled within 72 hours effer death with the Maryland tof Heelin and Mental Hygiene.  To the maryland many force of the than "natural", or items 23s or 28s-f show or other treumstic event, the Maryland Examinar must be mailfied at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Der Armed F 1 ☐ Yes If Yes, G Year or	orces? 2X No Sive	er in U.S.	If Ye	Decedent of H s, specify Cuba Yes 2 🕱 No	ispanic an, Mexi <i>Spec</i>	ican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh Specify: W	
within 72 ho ine. ihan "natur ihan "natur	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	rade completed	(1-4or 5+)		(Give kind life. DO f	s Usual Occup of work done o VOT use retired	during n i)	nost of work	ing		Kind of Business	•
2 should be filed within and Mental Hygiene. Is marked other than eumatic event, Item.		17. Father's Name (First, Middle, La	st)		( NC	gister	ed Nur Se		other's Name	e (First, Middle	_		e
id be lental ked c	To Be	George C.	Crass					L	ula		Hardi	man	
2 should 2 should and Men is marks reumatic		19a. Informant's Name/Relationship	(Type, Print)			-					ber, City	or Town, State,	Zip Code)
end 2 end 2 m 27 i		Mark C. Grabenstein-	son				fton Aven	_	-		21214		
Pa Paritir		20a. Method of Disposition  1 Burial 2X Cremation 3  4 Donation 5 Other (Spe	cify)	n State	Hilltop	Servi	<u>-</u>		12/4		To	wson, MD	
permit. Deperting Imports any injuice.		21. Signature of Funeral Service Lic	epeee Mill	1am G.	Dau		ime and Addres 05 Harfor						neral Home
Physician / Medical Examiner but sicien and stree private and stree private and street	dicai Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SEF  Due to  b. Due to  c. CEF	each line.  SIS  O (or as a color of the col	consequence of TALUR	on: E on:		g, such	as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death 10 HOURS
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours alter death.  To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		birth 2 [gnant at time	pregnancy ☐ Fetal death ne of death		opic pregnancy ner (specify)	,				23d. Date of de Month	elivery Day Year
quires that	by	Part II. Other significent conditions	contributing to	death but r	not resulting in	the under	lying cause giv	en in Pa	art I.		tobacco Yes 2	1	to the cause of death?  Probably 4 Unknown
The law reste has bee	Completed										s an opsy formed? 2 X N	prior to death?	
cien: ertific ector,	Be (	25. Was case referred to medical examiner?	Hospital: \	,			Oth		lace of Deat	h (Check only	one)		
Physic this of	To	1 ☐ Yes 2 No 27. Manner of Death		Inpatient e of Injury	2 ER/Ou	tpatient 3	BDOA Oth	4 _	Nursing Ho	me 5 ☐ Res 28d. Describe		6 ☐ Other (Spo	ecify)
To the Hospitel or Attending Physicien: within 24 hours elfer death of the Funerel Director: After this certifical completely filled in by the funeral director,	Certification:	1 Natural 5 Pending investigat 3 Suicide 6 Could no	5 Pending (Month, Day Year) Injury Work? Investigation M 1 Yes 2 No								Rural Route Number,		
pitei or A urs efter erel Dire		4 Homicide determine	buil	ding, etc. (	(Specify)			no data	and place	City or To			e stated
the Hosi hin 24 ho the Fune npletely fi	Medical	(Check only 2 Medicel Ex		basis of ex basis of ex anner states	camination and	d/or investi	igation, in my o	pinion,	death occur	red at the time	, date ar	s) and manner and place, and du ate signed (Mon	e to the cause(s)
To To cor	_	29b. Signature and title of certifier	1/	K	in		DE6				12	102	12004
.1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
Sta	te	31. Date filed (Month, Day, Year)		Registrar's		DRIV	E TOW	HÜE	, MOBA	ALAND -	111	1214	
Registr	ar	DEC 0 3 20	104	Drew	a f	1	pare	<i>j</i>					

			1 - For State Registrar	State o	f Maryla			of Health an of Death	d Mental Hy	giene 04	38290
	Physic /Medi		Decedent's Name (First, Middle, La.	Carvi		Ε.	Grimn	1	2. Date of De. Month Nov.	ath 29, 2004	3. Time of Death
	Exami	ner	4a. Facility Name (If not institution, giv. 3007 Delmar Avenu	e			Edg	vn, or Location of D		4c. County of D Baltim	ore Co.
	Funeral Director		5. Social Security Number 6. S 213-09-1396 1  Usual Residence of Decedent	ex ØM 2□F	7. Age (In yr 88	s. last birthday) Yrs.	If Under 1 Y Months Da		Hrs. 8. Date of Birt Min. (Month, Da June 3	y, Year)	Birthplace (State or Foreign Country) Maryland
	Maryland a-f ahow	ctor	10a. State 10b. County	imore	10c. (	City, Town or Lo	cation		Edgem	ere	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the 23a or 28	rai Director	10e. Street and Number 3007 Delmar A	venue			10f. Zip Cod	212 <b>1</b> 9		10g. Citizen of What United	
920	be filed within 72 hours after death with the Maryland lat Hygiene. d other then "natural" or items 23a or 28a-f ahow event, the Medical Evantrat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1 1 Yes If Yes, Giv Year or Da	rces? 2 🗍 No e		Was Decedent If Yes, specify ( 1 ☐ Yes 2 ☐	_	? (Specify Yes or No- uerto Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, /hite, etc. White
Maryland 21215-0036	within 72 ho ene. then "natur the Medical.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 9 Years		-4or 5+)	(Give	dent's Usual Ockind of work do	one during most of atired)	working	16b. Kind of Busine	
land 2	2 should be filed within and Mental Hygiene. Is marked othar then ' aumatic evant, Ite Ma	To Be Co	17. Father's Name (First, Middle, Last)  Spencer R. Gri	mm				18. Mother's	Name (First, Middle, Etta War	Maiden Sumame)	
	es 1 and 2 should b of Health and Ment of itam 27 is marked or other traumatice		19a. Informant's Name/Relationship (19a. Mrs. Mary Webb	<sup>Гурв, Print)</sup> / Daugh	ter	19b. Mailir 300	ng Address <i>(Sti</i> 07 De1ma	reet and Number of ar Avenue	r Rural Route Numbe E Edgemer	or, City or Town, State e, Marylan	e. <i>Zip Code)</i> nd 21219
Baltimore,	permit. Pages 1 Department of Hi Important: If itar any injury or oth	20a. Method of Disposition  1 Burial 2 Defendation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licence  20b. Place of Disposition (Name of cemetery, crematory or other place)  Hilltop Service Corp. 12/1/2004 Towson,  22c. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk,									
Ball	permit. Depart Import any inj		21. Signature of Funeral Service Licen				922 Wis	se Ave.	Dundalk, 1	Maryland	Inc. 21222
	Pnysician /Medical Examiner		23a art1. Enter the disease or comp shock, or heart failure cist only. Immediate Cause (Final disease or condition resulting in death)	a. Color	aused the deach line.  or as a conse	cen	er the mode of	dying, such as care	diac or respiratory ari	rest,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, and the innovation of the cause. Enter Undertrying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conse						
.O. Box 6	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ∏ Fel untattime of	tal death 3	Ectopic pregna Other (specify			23d. Date of o	delivery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions on Athlero School by	· / .	·-	esulting in the un	0.		23e. Did to	C. P.	to the cause of death?  Probably 4 □Unknown
Vital Records,		Completed	Emply sema						24a. Was a autops perfori	sy prior t med <sub>2</sub> ? death	autopsy findings available o completion of cause of ?
ŏ	Attanding Physicien: The Indeath. sector: After this certificate haby the funeral director, page	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	28a. Date o		⊒ ER/Outpatien 28b. Time of Injury	28c. i	0#	Death (Check only on g Home 5 Reside 28d. Describe ho		pecify)
Divis	Hospital or Attanding Ph. 24 hours after death. Funaral Diractor: After this tely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	buildin	g, etc. (Spec				City or Town	n, State)	Rural Route Number,
	To tha Hospital or within 24 hours afte within 24 hours afte To tha Funaral Diractompletely filled in the completely fill	Medical	29a. Certifier (Check only one)  1 ★ Certifying Phyone 2 ★ Medical Examone)  29b. Signature and title of certifier	rsician: To the iner: On the ba and mann	sis of examin	nowledge, death nation and/or inv	estigation, in m	e time, date and pla ny opinion, death or ense number	ace, and due to the coccurred at the time, d	ate and place, and d	ue to the cause(s)
	F 3 F 8		1 Robert But	H Standard	of death fire	m 22c) /T	D3	9440		9d. Date signed (Mo	79, 2004
	10		30. Name and address of person who of Robert C. Dout, 31. Date filed (Month, Day, Year)	Jr. 7	of death (Ite	with)	Point	es. Aco	limere	MD 211	19
8	Sta Registr		DEC 0 3 2004	Denis	Menal s Sign	The state	our				

				epartment of Health and Mental  Certificate of Death	Hygiene 004 38291
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Month	of Death 3. Time of Death
	/Medic	al	- Richard Givens	Nov	lember 29 2004 5-20 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) Future Care Irving ton	4b. City, Town, or Location of Death	4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7 Age (In vrs. last birth	Baltimore  Hoday) If Under 1 Year If Under 24 Hrs. 8. Date of	of Birth (2) Parity (2
	Director		219 30 2203	rs. Months Days Hours Min. (Month)	20, 1934 Virginia
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location	10d. Inside City Limits
	Mary B-f sh	tor	Maryland N/A	Baltimore	1 X Yes 2 ☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23a	rall	22-30 Athol Avenue	21229	USA
	fter de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married 2 ☒ Married  12. Was Decedent Ever in U.S.	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc.</li> </ol>	or No- 14. Race - American Indian, Black, White, etc.
98	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or Items 23e or 28e-f show other than "naturel", or Items 24e or 28e-f show event, I're Medical Evarilizer mind be inclified at	by	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give Year or Dates:	1 ☐ Yes 27 No Specify:	Specify: Black
5-0	72 hd "natu	Completed	15. Decedent's Education 16a. I (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of working	16b. Kind of Business/Industry
12	within ene. than	Jup	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	Constant time
р 2	filed Hygi other	Be Co	17. Father's Name (First, Middle, Last)	aborer  18. Mother's Name (First, Mic	Construction  ddle, Maiden Surname)
/lar	wild be Menta Menta arked	To B	John Givens	Ethel Melvir	1
Maryland 21215-0036	12 sho			Mailing Address (Street and Number or Rural Route No	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If the 27 is marked other than "naturel; or flems 23a or 28e-f show any injury or other treumetic event, the Medical Examinating the publical anone.			A18 Alan Drive, A.t. E B Disposition (Name of crematory or other place)	altimore, MD 21229  20c. Location City or Town, State
Baltimore,	Pages ent of nt: If Ii		1 - Danial - Apolemation - 0 - 1 lenioval noil State	rematory or other place) rematory, Inc. 12/1/04	
alti	permit. Departm Importe any inju	ĺ	21. Signature of Funeial Service Ligenseen Communication	22. Name and Address of Facility of MD	Baltimore, Mu
	89 E 29		Dawn F. McDonald	Cremation Society of MD 299 Frederick Road Balt	imore, MD 21228
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac or respirato	ry arrest, Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)	2 Dementiq	5.1001 4.10 534.11
	Examiner		Dellaro cale		disease
	P ##	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	):	
Yi	be executed icien and burial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	).	
8760,	The law requires that the death certificate be exective that be exective that has been signed by the attending physicien and bage 2 should be detached for use as the burial-transpace.	dlcal E		,	
9	ntificat ng ph) s as th	Medi	IF FEMALE:		
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	3 ☐Ectopic pregnancy	23d. Date of delivery  Month Day Year
o.	that the de ed by the a detached	by Physician/Me	1 Yes 2 No 9 Unknown  4 Pregnant at time of death 9 Unknown	5 Other (specify)	- Say Fall
a. O	res that igned b be deta	y P	Part II. Other significent conditions contributing to death but not resulting in t	the underlying cause given in Part I. 23e. D	Did tobacco use contribute to the cause of death?
Zď	w require been sig should b	ted t		1	☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩nknown
Records,	has be	Completed		a	Vas an 24b. Were autopsy findings available utopsy prior to completion of cause of
				ı 1 ☐ Ye	erformed? death? ss 2☑No 1☐Yes 2☑No
Vital	ysicien: nis certifica director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	26. Place of Death Check on attent 3 DOA Other:	afy one) Besidence 6 □Other (Specify)
ס ר	ding Phy h. After thi funeral o	T :u	27. Manner of Death 28a. Date of Injury 28b. Tir	ne of 28c. Injury at 28d. Descri	be how injury occurred
Sior	Attendir death. ctor: Af y the fur	catlo	1 Accident investigation 3 Suicide 6 Could not be	M 1 □ Yes 2 □ No	
Division of	or At after d Direct in by	Certification;	4 Homicide  determined  28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office 28f. Locatio City or	on (Street and Number or Rural Route Number, Town, State)
	spitel hours nerel y filled		29a. Certifier 1 Certifying Physicien: To the best of my knowledge,	death occurred at the time, date and place, and due to	the cause(s) and manner as stated.
	To the Hospitel or Attending Physicien: A thours after death To the Funerel Director: After this certifica completely filled in by the funeral director.	Medical	one) 2 Medical Exeminer: On the basis of examination and/	or investigation, in my opinion, death occurred at the tin	ne, date and place, and due to the cause(s)
	with To To	2	29b. Signature and title of certifier  Arosto Wilceley	29c. License number	29d. Date signed (Month, Day, Year)
		-	30. Name and address of person who completed cause of death (Item 23a) (T	Una Print)	Malember 30,2004
	C Abree		AMATUM N LIARM, 50	Dolphins F. Balt	o, MD 2/2/7
	Sta Registra		31. Date filed (Month, Day, Year)  DEC 0 3 2004  32. Registrar's Signature	& Sports	

			1 - For Stete Registrar	State of	of Marylan		artment of rtificate o			Mental Hygi	iene (	004	382	92
ı	Physici		1. Decedent's Name (First, Middle, Last	•	Kenneda					2. Date of Death Month November	Day	Veer	3. Time o	f Death
1	/Medic Examir		4a. Facility Name (If not institution, give Montgomery Hospice	street and nu	ımber)	<i>y</i> - 3.5 <u>F</u>	4b. City, Town	, or Location			4c. Cou	nty of Death		, A
P.	Funeral Director		377-20-4074	x □M 2 <b>∑</b> F	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Day	ar If Uno	der 24 Hrs.	8. Date of Birth (Month, Day, Feb. 26,		9. Birth	lace (State	
	be filed within 72 hours after death with the Maryland death Hyglene. d other than "naturel", or Itams 23s or 28s-f show event. It a Medical Examinet must be redified at	al Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome  10e. Street and Number  11924 Canfield Ro		10c. Cit	y, Town or Lo	otomac 10f. Zip Code	)854				of What Cour	ntry?	ity Limits 2KI No
9500-	2 hours after deat atural', or Itams 2 cal Examiner mu	ted by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu	Armed For 1 Yes If Yes, Gin Year or Ducation	2 X No ve Dates:	16a. Deced	Vas Decedent of Yes, specify Cu	f Hispanic iban, Mexi o Spec	ify:	pecify Yes or No- Prican, etc.)	14. F E Spe	Race · Americ Black, White,	ean Indian, etc. hite	
21215-003	filed within 7. Hygiene. thar than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	College (		(Give life. L	kind of work dor DO NOT use reti emaker	e during m		ang	Ov	vn Hom	•	
Maryland	d 2 should be f th and Mental H 7 Is markad of traumatic eva	To Be	Leroy deGraffenre  19a. Informant's Name/Relationship (7)			19b. Mailin	a Address (Stre	Do	orothy	e (First, Middle, M y Knapp al Route Number,			Code	
Baitimore, Ma	permit. Pages 1 and 2 Department of Health a Important: If itam 27 ls any injury or other trai		Ray Gasper/Husband  20a. Method of Disposition  1  Burial 2  Cremation 3 F  4  Donation 5 Other (Specify)	Removal from	C6	11924		ld Ro	oad, I	Potomac, Date 2,	Mary1 Oc. Locatio		0854 wn, State	d
Bair	permit Departi Import any inj once.	ls i	21. Signature of Funeral Service Ilcens		M001	L98 300	Name and Add bert A. West Mc	ress of Far Pump ontgoi	hrey nery A	Funeral l	Home/			
	/Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	each line.  Ly Metas  (or as a consequ  (or as a consequ  (or as a consequ	static uence of): uence of):							Approximate Interval Bett Onset and D	ween
O. BOX 68/60,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d 3c. If yes, out 1 □ Live b	come of pregnar	ncy death 3	Ectopic pregnan Other (specify)	су				Date of delive.		'ear
cords, P.	The law requires that the take has been signed by the page 2 should be detache	þ	Part II. Other significant conditions cor	tributing to de	eath but not resu	iting in the un	derlying cause g	iven in Par	t I.	23e. Did toba		ntribute to the		
vital Reco	an: The law re tificate has be or, page 2 sho	e Completed	25. Was case referred to medical					00 PI		24a. Was an autopsy performe	d?	. Were autop prior to corr death? 1 \( \text{Yes} \)	pletion of ca	ivailable use of
SIOH OF AL	hysi his c	Certification: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Notatural 5 Pending 2 Accident investigation	28a. Date of		ER/Outpatient 28b. Time of Injury	28c. Inju	her: 4 🗆 I	Nursing Hor	n (Check only one) me 5 Residence 28d. Describe how	e 6 🖾 O	ther <i>(Specify,</i> Irred	Hosp:	ice
	pital or Atl rurs after d aral Direct illed in by t		3 Suicide 6 Could not be determined	buildir	of Injury - At hor ng, etc. (Specify)	)				28f. Location (Stree City or Town, S	State)			99 <i>r</i> ,
	To the Hos within 24 ho To the Fun completely i	Medicai	29a. Certifier (Check only one)  1	ner: On the ba	isis of examination	vledge, death on and/or inve	estigation, in my	ime, date a opinion, de se number	eath occurre	ed at the time, date	and place	anner as sta , and due to ed (Month, D	the cause(s)	
C	6		30. Name and address of person who co					41.	218		11/3	0/0	4	
0	Stat Registra	. 1	Charles Harrison, 31. Date filed (Month, Day, Year) DEC 0 3 2004		6001 Mun		Mill F	Road,	Rocky	ville, Ma	rylar	nd 208	55	

			For State Registrar		State o	f Marylaı		artmen				fental Hy	giene	004	382	93
	Ø2.		1. Decedent's Name	(First, Middle	e, Last)							2. Date of De	ath		3. Time	
	Physic /Med		Eleano	r Lee	Groves							Novemb	er 24	, 2004	1:31	AM M
	Exami				n, give street and nu			4b. City,	Town, or	Location	of Death			unty of Dea		
					ty Genera					ster				arrol1		
1	Funeral		5. Social Security N		6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 72	. last birthday) Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da NOV 26	h y, Year)	9. Bir	thplace (State ountry)	or Foreign UNK
	Director		232-54-32 Usual Residence of			12						NOV 26	, 1931	· ]		
	Maryland -f show		10a, State	10b. County		10c. C	ity, Town or Lo	cation							10d. Inside (	City Limits
2	Man H-1 sh	to	MD	Car	roll		West	minst	er						1 🗆 Ye	s 2X No
0	ith the M or 28a-f	irec	10e. Street and Nun	nber				10f. Zip	Code				10g. Citizer	of What Co	Lountry?	
EAND	23a c	Funeral Director	127 Stor	ner Ave	nue					21157	7			USA		
6	ter dea itams	Iner	11. Marital Status	u	nk 12. Was Dece	edent Ever in U	J.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	14.		encan Indian,	
	E Q 24 €	by Fu	1 Never Marrie		If Yes, Giv	/e	ink	1□ Yes		Specify:		7.7021.1, 010.7			hite	
D 3500		q pe	3 Widowed	15. Decedent	Year or D	ates:	16a. Dece	da asta I lava	10	No.		1				
V) H	- c * 6	olet		fy only highes	t grade completed)		(Give	kind of wor DO NOT us	k done d e retired	ition <i>luring mos</i> i )	t of work	<sub>ing</sub> unk	16b. Kind	of Business	/Industry	unk
100	3 with giene r tha	mo	Elementary/Secor unk	ndary (0-12)	College (1 unk	-4or 5+)			,							
10	al Hyg	Be Completed	17. Father's Name (	First, Middle,	Last)				unk	18. Mothe	r's Name	First, Middle,	Maiden Su	mame)		unk
X i	should b nd Ments markad umatic e	To	_													
GRO	permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any njury or other traumatic event, In Mence.		19a. Informant's Na				19b. Mailir	ng Address	(Street a	nd Numbe	or Aura	al Route Numbe	r, City or To	wn, State,	Zip Code)	7
	and and ealth m 27				General					Aver			ster,	MD 2	1157	
Bolting Cross	ges 1 F of H if ite		20a. Method of Disp 1 Burial 2 [	Cremation	3 ☐Removal from	State	Place of Dispo cemetery, cren	sition <i>(Nan</i> natory or o	ne of her place	9)	[	Date	20c. Locat	ion - City or	Town, State	
3	tmen tant:		` 4 □ Donation	5 🛚 Other (Sp	pecify) in sta	ate				į						
G	permit Depar Impor any in		21. Sit nature of Eur Ro	nelal Service I	icensee , D	irecto	r   St	. Name and	d Address	ony B	y oard	655 W.	Ralt	imore	Stroot	
	40140		23a. Part V. Enter th	24/	Wall		Ва	ltimo	re,	MD :	2120	655 W.		rmore		
	(Kara 1979)		SHOUR, OF HEAT	t fallure. List i	complications that conly one cause on e	ach line.	in. Do not enti	or the mode	or dying	, such as	cardiac o	or respiratory an	rest,		Approxima Interval Be Onset and	tween
	Prrysician /Medical		Immediate Cause (I disease or condition resulting in death)	rinai 1	_ a C	irel	iae	HA	$\mathcal{M}$	my	al				Onsot and	Double
	Examiner		,		Due to (	or as a consec	quence of):	+								
		e e	Sequentially list con	ditions,	b. Due to (	UF as a consec	quence of):	-								
	uted d ansit	Examiner	Sequentially list con if any, leading to fin cause. Enter Under Cause (Disease or i that initiated events	tying njury		CHE	=									
_	sate be executed oblysician and the burial-transit	Еха	resulting in death) L	ast	c. Due to	or as a conseq	quence of):	~						-		-
8760	ate be	cai			d.	SYC	cho.	SIC						- 1		
Œ	ng ph	Physician/Medical	IE FEMALE			J		_								
Box	The law requires that the death certitic law requires that the death certitic late has been signed by the attending plage 2 should be detached for use as	an/h	IF FEMALE: 23b. Was decedent		23c. If yes, out	come of pregna		Ectopic pre	nnancy				23d.	Date of deli		
п.	e dea he at hed fo	sici	in the past 12 r			ant at time of d		Other (spe						Month	Day	Year
0	that the de led by the a	Phy	9 Unknown									T				
	signed I	þ	Part II. Other signific	cant condition	ns contributing to de	ath but not res	sulting in the un	iderlying ca	use giver	n in Part I.					the cause of	_
Š	w requir been si should	etec										1 1	es 2 N	o 3∐Pn	obably 4 🔃	LIARNOWN
Division of Vital Becords	sician: The faw s certificate has b lirector, page 2 s	Completed										24a. Was a autops	sv	prior to d	topsy findings completion of a	available ause of
7	Th icate r. pag											perfor 1 ☐ Yes	2 No	death?	2□ No	
<u> </u>	Physician: this certificant	o Be	25. Was case referre	ed to medical	Hospital:							(Check only or				
Ď.	ding Physician: h. Atter this certific funeral director,	III.	1 Yes 2 27. Manner of Death	10	1 (34)		ER/Outpatient		c. Injury	'4 □ Nur at		ne 5 Reside			eify)	
2	Attending F r death. ector: Atter	tior	1 Natural 2 Accident	5 Pending		f Injury h, <i>Day Year)</i>	Injury	М	c. Injury : Work?	es 2 □ N		.oa. Doodiloo iii	ov injury oc	Culloc		
<u>v</u>	Attendi	Hica	3 Suicide	6 Could n	ot be 28e. Place	of Injury - At he	ρṃe, farm, stre	et, factory,	office		2	28f. Location (Si	reet and No	ımber or Ru	ral Route Num	iber,
i	s afte	Certification;	4 🔲 Homicide		buildir	ig, etc. (Specif	<i>y)</i>					City or Town	7, State)			
	To the Hospital or Attention within 24 hours after death To the Funeral Director: completely tilled in by the		29a. Certifier (Check only	1 Certifying	Physician: To the	best of my kno	wledge, death	occurred a	t the time	, date and	place, a	and due to the ca	ause(s) and	manner as	stated.	
	To the H within 24 To the F complete	ledicai	onel	2 Medical E	xaminer: On the ba and mann	er stated.	ition and/or inv	estigation,	in my opi	nion, deati	h occurre	ed at the time, d	ate and pla	ce, and due	to the cause(s	5)
	With To I	Σ	29b. Signature and t	te of certifier	0 1.0	0 1	MA	29c.	License	number	42	10 2	9d. Date sig	ned (Month	Day Year)	
			MALI)	W.	Luc	4		1	-0	03	TE	13	11-	44-	04	
			30. Name and addre	ss of person w	( ) E A		n 23a) (Type, F	Print)	0.	1	0	va lab.	2 - 20.	s. ch	MIN 2	1150
	0.		31. Date filed (Month	Mah Year	1- 1-	gistrar's Signa	J 7 ]	1-10	u CII	14 0		m, 100	11 mg	71709	4 -	/
,	Sta Registi	rar	31. Date filed (Month	0 3 20	04 Jan	Market Solding	B.	lon.	1			ind due to the cad at the time, d				
		12-15					<u></u>	a marine	13							

			For State	State of Maryla	and / Dep	artment of Healtl	h and Mei		Wild - Ch. 1	38294
	Dhusisi		Registrar  1. Decedent's Name (First, Middle, La	ist)		runcate of Dea		Date of Death Month	g. No. Day Ye	3. Time of Death
	Physici /Medic	al	4a. Facility Name (If not institution, gi	C. Hest	<u> </u>	4b. City, Town, or Locati			28 201 4c. County of E	4 3:57AM
ı	Examin	ler	North Arunde	1 Hospital		Glen Bur	nie		Anne	Arundel
	Funeral Director		, , , , , , , , , , , , , , , , , , , ,	Sex 7. Age (In yi	rs. last birthday) Yrs.	Months Days Hou	ırs Min.	Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)  NC
	ow ow		Usuel Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	8e-f sh	ctor		Arundel		Severna Park	k 	·····		1 ☐ Yes 2 🔀 No
	h with th	Funeral Director	10e. Street and Number 253 Perch Road			10f. Zip Code 2114	46	10	g. Citizen of Wha	t Country? USA
	ltems i	uner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify cican, Puerto Ric	y Yes or No- an, etc.)		American Indian, Vhite, etc.
0000	be filed within 72 hours after death with the Maryland the Hyglene. A let Hyglene do the then "naturel", or Items 23a or 28e-f show do ther then "naturel", or Items 23a or 28e-f show event, it e Marical Examirer must be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	Korea	1 ☐ Yes 2 ☑ No Spec	cify:		Specify:	White
ה ה ב	hin 72 h s. on "natu Medica	Completed	15. Decedent's E (Specify only highest gi	Education rade completed)  College (1-4or 5+)	16a. Dece (Give life.	edent's Usual Occupation is kind of work done during r DO NOT use retired)	most of working	1	6b. Kind of Busing Bitumi:	· ·
777	iled with Hygiene ther the nt, Ibe		12		Vice	President/Ge	en. Mana lother's Name (F		Constr	uction
/land	uld be f Mental P irked of	To Be	Ralsey Hester				annie Po		alder Surrame)	
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Instruction: If item 27 is marked other then "naturel; or tiems 23a or 28e-1 show mary injury or other treumatic event, it a Madical Examiner must be notified at once.		19a. Informant's Name/Relationship Eileen Hester/W.			ing Address (Street and Nui 3 Perch Road,				te, <i>Zip Code)</i> 1146
ore,	jes 1 ar of Hea If item or or other		20a. Method of Disposition 1 区Burial 2 □ Cremation 3	Domeyal from State	_cemetery, cre	osition (Name of matory or other place)	Dec.	·	0c. Location - City	
апшог	nit. Pag artment ortant: injury o		<ul> <li>4 □ Donation 5 □ Other (Spec</li> <li>21. Signature of Funeral Service Lice</li> </ul>	ify) G		en Memorial  2. Name and Address of Fa	200	)4	Glen Bur	
ñ	Per Per Per Per Per Per Per Per Per Per		Thomas I	1/4		495 Gov. Rito	chie Hwy	. Seve	rna Park	
	Physician		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	ipplications that caused the de one cause on each line.	eath. Do not en	iter the mode of dying, such	n as cardiac or re	espiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a. Due to (or as a cons	equence of):	unce				
ķ.	•	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	equence of):					
	xecuted and al-transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cons	equence of);					
8/e0	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dical E		d						
POX PS	certifica nding pl use as t	0	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred					23d. Date of	delivery
ă C	res that the death certificing the detached for use as be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2□Fo 4□Pregnant at time o 9□Unknown		_Ectopic pregnancy ☐ Other (specify)	<u></u>		Month	Day Year
	s that th	by Phy	Part II. Other significant conditions	contributing to death but not i	resulting in the u	underlying cause given in Pa	art I.	23e. Did toba	acco use contribut	e to the cause of death?
necords	requii							1 🗌 Yes		Probably 4 Unknown
Ľ	sicien: The law s certificate has b lirector, page 2 s	ompieted						24a. Was an autopsy perform	prior	
VII.al	Physicien: this certifica ral director, p	BeC	25. Was case referred to medical examiner?	Hospital:		Othor	lace of Death (C	heck only one	)	
I 0	Phy this	on: To	1 ☐ Yes 2 No  27. Manner of Death 12. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	HI 3 DOA 4L			nce 6 Other (S v injury occurred	Specify)
UNISION	Attendii death. ctor: A y the fu	ertification:	2 Accident investigation 3 Suicide 6 Could not	be 28e. Place of Injury - Al	t home, farm, st	M 1 ☐ Yes 2		Location (Stre	eet and Number o	r Rural Route Number,
S	urs after ral Dire	O.	4 - Horniciae	building, etc. (Spe				City or Town,	,	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one)  1 Certifying P 2 Medical Exe	hysicien: To the best of my k miner: On the basis of exam and manner stated.	(nowledge, deal ination and/or in	th occurred at the time, date nvestigation, in my opinion,	e and place, and death occurred a	due to the cau at the time, dat	use(s) and manne te and place, and	r as stated. due to the cause(s)
	To th To th comp	Ň	29b. Signature and title of certifier	O. Law	18000	29c. License numb	5972		d. Date signed (M	onth, Day, Year)
	NX1		30. Name and address of person who	-	tem 23a) (Type,	Print) A D I			0	2004
	Sta	ete	Adeyinka O.L. 31. Date filed (Month, Day, Year)	alyemo mi) 32. Registrar's Sig		Arundel +	tospita	, Glev	n Burnu	e, mD 21061
	Registi		DEC 03	2004 Dene	ma /	y Sporks	/			

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Reg. No.	38295
E	Dhusisian	Decedent's Name (First, Middle, Lest)		2. Date of Death  Month Day Year	3. Time of Death
4	Physician /Medical	Gene J. Heatwole		November 24, 2004	11:35 AM
1	Examiner	4a Fecility Name (If not institution, give street end number)	4b. City, Town, or L		
		12414 Bowling Street SW	Cumberl	-0	-
۰	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. la 1 M 2 □ F 76	Ast birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	(Month, Day, Year) Count	lece (State or Foreign try) : Virginia
	pu *	Usuel Residence of Decedent  10a. State 10b. County 10c. City.	. Town or Location		0d. Inside City Limits
	Ba-f sho	MD A11	Cumberland		1 ☐ Yes 2 No
	ath with the Merylen 23a or 28a-f show wat be notified at	10e. Street and Number 12414 Bowling Street SW	10f. Zip Code 21502	10g. Citizen of What Count	try?
020	urs aftar de al', or ftema mantiner m by Fune	3 ☐ Widowed 4 ☐ Divorcad If Yes, Give Year or Dates: 150 —	If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Diction, etc.)  14. Raca - America Black, White, e Specify: Whi	etc.
5-0	72 hc	15. Decedent's Education (Specify only highest grade completed)	16a. Decadent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business/Ind	lustry unk
2121	within	Elementery/Secondary (0-12) College (1-4or 5+) unk unk	life. DO NOT use retired) printer		
Maryland 21215-0020	tal H od out	17. Father's Name (First, Middle, Last)  Charles H Heatwole		e (First, Middle, Maiden Surname) 1 Jackson	
ary	d 2 should th end Men 7 is marke traumatic	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run	ral Route Number, City or Town, State, Zip	Code)
Σ	1 and 2 Heelth e em 27 ls	Lois Heatwole/spouse	12414 Bowling Street	t SW Cumberland, MD	21502
Baltimore,	(A 40 U	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 💆 Donation 5 ☐ Other (Specify)	ace of Disposition (Name of metery, crematory or other place)	Date 20c. Location - City or Tox	
Balt	permit. Pages Departmant of Important: if I any Injury or pnce.	21. Signature of Emera) Service Licensee Romald S. Wale, Director	22. Name and Address of Facility State Anatomy Board Baltimore, MD 2120	1 655 W. Baltimore S	treet
		23a Part1. Enter the discusse, or implications that caused the deeth. nock, or heert failure. List only one cause on each line.			Approximate Interval Between
1	Physician	Cook, or need failure. Elst only one cause on each line.			Onset and Death
A	/Medical Examiner	Immediate Cause (Final disease or condition	cer y Proteto		1927
		resulting in death)  a.  Due to (or	as a consequence of):		
	nsit	b		1	
	ficeta be executed physician end is the buriel-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	as a consequenca of):		
68760,	ysicial ysicial e buri	Cause Disease or injury that initiated events  Due to (or a	as a consequence of):		
89 xc	E 0 5				
Bo	eath affor u	Part II Other significant and distance and the first to death but not applied	in the second of	02h Didahaan aan ah bahaa	
P.O.	es that the death or igned by the attend be detached for us by Physician/	Part II. Other significant conditions contributing to death but not result	ing in the underlying ceuse given in Part I.	23b. Did tobacco use contribute to	the cause of death? ably 4 □ Unknown
S,	s that gned se del				,
Division of Vital Records,				performed? avai	re autopsy findings ilable prior to npletion of cause leath?
æ	The law ate has the page 2 s			1	Yes 2□ No
<u>a</u>	artifica actor, p	25. Was case referred to medical	26. Place of Deat	h (Check only one)	
<b>&gt;</b>	Physician: rthis cartific oral director, r: To Be (	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3□ DOA Other: 4□ Nursing Ho	ome 5-Residence 6 Other (Specify)	)
o uo	nding Phath.: After the funeral	27. Menner of Deeth 1 ☐ Naturel 5 ☐ Pending 2 ☐ Accident investigation	28b. Time of 28c. Injury et Work?  M 1 Yes 2 No	28d. Describe how injury occurred	
Divis	its or Attending P is after death.  Is Director: After t led in by the funers  Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Pleca of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (Street and Number or Rural City or Town, State)	Route Number,
	To the (hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this cardificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowl on the basis of examination and manner stated.	edge, deeth occurred at the time, date and place, in and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as ste red at the time, date and place, and due to	ited. the cause(s)
	Within To the complete Me	29b. Signature and title of cartifier	29c. License number	29d. Date signed (Month, D	lay, Year)
		> Tallow 20	D001756	5 hr. 24, 20	.4
			13e) (Type, Print) L2 Key 1 Aug L2	bute, (7 1 2150	
	State Registrar	31. Date filed (Month, Day, Year)  DEC 0 3 2004  32. Registrer's Signatu	1230) (Type, Print) 12 Net 1 Huy L2 10 10 10 10 10 10 10 10 10 10 10 10 10	, , , , , , , , , , , , , , , , , , , ,	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Day December 01, **Physician** Hepple 0220 AM (harles 2004 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City The Johns Hopkins Hospital N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye May 27, 1 6. Sex **Funeral** 1**⊠** M 2□ F 213 28 6610 Yrs. Maryland 73 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location d other than "natural", or items 23s or 28s-1 show event, the Mudical Exercited returns be notified at 1X Yes 2 No N/A Baltimore Maryland Directo 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 123 S. Wolf Street 21231 U.S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status tiled within 72 hours after 1 ☐ Never Married 2 ☐ Married 1XYes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: à 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Career Military Army 12th Pages 1 and 2 should be filed venent of Health and Mental Hygie ant: If item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Hepple Margaret (not available) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brenda Shetterly / Daughter 529 Pontiac Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages:
Department of timportant: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 12/3/2004 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Puneral Service Licens 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Pert1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic disease lung 2 months /Medical Due to (or as a consequence of): **Examiner** Primary malianancy Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform infatchion myocardial P No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA 2 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29c. License number ▶ Cristine E Berry, Medical Dock RES-000 December 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towar 110, Doctor's Large 600 N. Wolfestreet Bultimore, Maryland 21287 Chistine E. Berry Johns Hopkins Hospital 21287 31. Date filed (Month, Day, Year)
DEC 03 2004 32. Registrar's Signature State Board! Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 9:05 a M Elisabeth A. K. Jordan 17 2004 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Edenwald Towson **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Mar 2, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 💢 F 95 Germany 217-80-0342 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Modical Expediment out be notified at MD 1 ☐ Yes 2/☐ No Baltimore Towson Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify Specify: white ڄ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) housewife own home permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Itam 27 is marked othe any jury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hans Lehmann Amalie Bock ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elke Jordon/daughter 10114 Fleming Avenue Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 neral Se vice Licensee 21. Signature of Funeral Ser Ronal Baltimore, MD mare Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a I be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown plnous Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 24 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 1 Yes 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ Nο 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation Director: 3 🗆 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funaral Direc 4 🖺 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 228 30. Name and address of person who completed cause of death (Item ð buenn marce 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 3 2004 Registrar

			T TOUGE T	•	epartment of Health and N	•	e e	
		•	1 - For State Registrar	-	Certificate of Death	Reg. N	Z11114	38298
	*	¥ <sub>2</sub> .	Decedent's Name (First, Middle, Last)	)		2. Date of Death		3. Time of Death
	Physici /Medic		John .	lordan		November 2	-8, 2004	2110 M
	Examir	25.5	4a. Facility Name (If not institution, give si	/	4b. City, Town, or Location of Death	4	c. County of Death	
	4.	*	21110011100	of Baltimore	Baltimure Cit	4	NIA	
	Funeral		5. Social Security Number 6. Sex	M 2□F 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthpl	place (State or Foreign
	Director	4	Usual Residence of Decedent	85	13.	8 // /9	119 North	ti Carolina
	/land		10a. State 10b. County	10c. City, Town	or Location		1	0d. Inside City Limits
2	Man a-f sh	tor	Md. N/A	Balt.	imare			1 Ves 2 No
la	th tha	irec	10e. Street and Number	1	10f. Zip Code	10g. C	Citizen of What Coun	ntry?
Jordan	death with tha Maryland ms 23a or 28a-f show	a	4910 Nelson	HUE.	2/2/5		USF	7
13	er des tems	nue		Was Decedent Ever in U.S.     Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs after i', or ite	y F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 □ No YYes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	30 V
5 John 21215-0036	72 hours after death with tha Maryla "neturel", or tems 23a or 28a-f shov	Completed by Funeral Director	15. Decedent's Educ		Decedent's Usual Occupation	16b.	Kind of Business/Inc	dustry
13. 55	within 72 ene. than "nel	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) (	Give kind of work done during most of work life. DO NOT use retired)	king	1 /	1
212	d with giene	mo	Generally (0-12)	College (1-401 37)	Welder	N	ld. Dryd	OCK_
Q E	ba filed tal Hygi d other event, L	Be (	17. Father's Name (First, Middle, Last)	1	18. Mother's Nam	e (First, Middle, Maide	in Sumame)	
Z A	s should be filed within 72 hours after death with tha Marylar and Mental Hygiene. Is markad other than "neturel", or Items 23a or 28a-f show aumatic event, the Marylad Examither mast be notified as	To	Henry Jor	dan	Mar	YP. JOI	rdan	
Jar Har	2 sho and is ma		19a. Informant's Nam - Relationship (Typ	pe, Print) (WIFE) 19b.	Mailing Address (Street and Number or Rui	all Foute Number, City	or Town, State, Zip	Code)
o. N	of Health litem 27		Mrs. Esther Lee	Jordan 120h Place of 1	Disposition (Name of	Date 20c.	Location - City or To	-15
+ F	Pages 1 nent of H int: If ite		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	, crematory or other place)	12/2000	Location - City of To	WII, State
Heat Known a Baltimore, Maryland	nit. Pages 1 and 2 should be filed withir artment of Health and Mental Hygiene. ortant: If item 27 is marked other than injury or other traumatic event, Ite M. 9.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	1 6 ar	1 SOO   / L/ 22. Name and Address of Eacility	11200404	1119514	1115,11 He
Pathent Known  Baltimore, Maryla	permit. Pages Department of Important: If i any injury or once.		March L- 1	1111)	Joseph L. Russ	Funera	Home more in	1 21216
12 I	Town The		23a. Int1. Enter le disease, or complic	cations that caused the death. Do no	ot enter the mode of dying, such as cardiac		more, ne	Approximate Interval Between
	Physician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	ire.		_	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of	f):			( days
	Examiner		Sequentially list conditions	Sepsis				
	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or all a consequence of	f):			
	acute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	۸۰			
760.	ita be exacuted iysician and ne burial-transit	calE		200 10 (01 20 2 2011004201100 01	·/·			
687	5 S		d					
Box (	leath cartificat attending phy I for use as th	N/W	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy			23d. Date of delive	ary
ă	death e atte	Iclai	in the past 12 months?	1☐Live birth 2☐ Fetal death 4☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
0.9	t the by the tache	hys	9 Unknown	9□ Unknown				
	The law requires that the death cartifica te has been signed by the attending ph page 2 should be detached for use as the	by Physician/Med	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.		use contribute to th	
ord	w require been sig should b	ted				1 ∐ Yes	2 □ No 3 □ Prob	ably 4 @Onknown
Records.	e law r has be je 2 sh	Completed				24a. Was an autopsy	24b. Were autor prior to cor	psy findings available mpletion of cause of
<u> </u>		Co				performed2 1 ☐ Yes 2 ☐ N	lo 1 Yes	2 No
× ∏ital	Physiclen: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:	Othor	th (Check only one)		
9	Phy this	. To	1 Yes 2 No	1 Minpatient 2 LEP/Out	patient 3 DOA 4 Huising III	ome 5 Residence 28d. Describe how inj		1)
n o	ding T. After fune	tlon	1 Natural 5 Pending 2 Accident investigation		me of 28c. Injury at Work?  M 28c. Injury at Work?  1 □ Yes 2 □ No	,	.,	
Division	Attending or death. actor; After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, fare	m, street, factory, office	28f. Location (Street a		l Route Number,
á	al or	Certification;	4 Homicide	building, etc. (Specify)		City or Town, Sta	<i>te)</i>	
	To the Hospital or Attend within 24 hours after death To the Suneral Diractor: completely filled in by the		29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge,	death occurred at the time, date and place, for investigation, in my opinion, death occur	and due to the cause(	(s) and manner as st	ated.
	the H in 24 the Fa	ledical	one)	and manner stated.				
	To the within 2 To the comple	Σ	29b. Signature and title of certifier		29c. License number	29d. 0	Date signed (Month, I	Day, Year)
				U Spivita	16123-00	Nove	ember 18	,2004
	X		39. Name and address of person who con	mpleted cause of death (Item 23a) (T	RES-00 Type, Print) SWAIHOSPITA	OFB	AID INDE	200=
	y St	ate:	31. Date filed (Month, Day, Year)	32. Registrar's Signature	71101111 - STITE	C 01 1/1	17010	···
	Regist		DEC 0 3 2004	Beede # 16	ask s			

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Mont

Year)

2004

sacks!

32. Registrar's Signature

		•	For State Registrar	State of Marylan		artment of H			ental H	ygiene Reg. Nd	2001.	3831	0.0
			Decedent's Name (First, Middle, La	st)					2. Date of D	eath		3. Time of De	eath
	Physicia /Medic		HANS M J	ONSSON SR.					Month  OVEM	Da: BER		14 05:18	an M
Day.	Examin		4a. Facility Name (If not institution, giv	· · · · · · · · · · · · · · · · · · ·		4b. City, Town, or	Location of	of Death		4c.	. County of Dea		
			Saint Joseph					OWSO				timore	
	Funeral Director		5. Social Security Number 6. S 207-24-8810	ex 7. Age (In yrs. 7		If Under 1 Year Months Days	If Under Hours	Min.	B. Date of E (Month, L MAY 1	Day, Year)	0	thplace <i>(State or F</i> ountry) EDEN	oreign
	P.		Usual Residence of Decedent								0 , 0, 1, 2		
	arylar show	_	10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City I	
	8a-f	Director	MARYLAND HARFOR	D CO.	ABERDE					1			W)140
	with ti	Ö	10e. Street and Number			10f. Zip Code					tizen of What C	ountry?	
	eath	era	918 EDMUND STR	EET  12. Was Decedent Ever in U.	.S. 13. V	21001 Was Decedent of H	ispanic Ori	gin? (Spec	ify Yes or N		14. Race - Am	erican Indian.	
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy origing or other traumatic event, It a Madical Exactifier and be notified at once.	by Funeral I	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1XXYes 2 □ No If Yes, Give Year or Dates: 50/7		f Yes, specify Cuba 1 ☐ Yes 2 <b>\CX</b> No	n, Mexicar Specify:	i, Puerto R	ican, etc.)		Black, Whi	te, etc.	
21215-0036	hour tural	ed b	15. Decedent's E			dent's Usual Occupa	ation			16b K	ind of Business		
5	in 72 n "na	Completed	(Specify only highest gra	de completed)	(Give	kind of work done of DO NOT use retired	durina mos	t of workin	g	TOD. IX	and or business	willdostry	
212	d with giene. r tha	mo	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	MED	SUPPLY S	GT				ARMY		
פר	e filed al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last	}			18. Mothe	er's Name	(First, Midd	le, Maiden	Sumame)		
<u>la</u>	Menta Menta arkad atic e	70	ANDRE JONSSON				KA	RIN I	ELISAE	ET R	oos		
Maryland	2 sho	1	19a. Informant's Name/Relationship (		)	ng Address (Street a				•			
e) O	1 and tealth sm 27 ther t		Iwanka Jonsson/W			Edmund S sition (Name of	t., A	berde Da			and 210 ocation - City or		
וסר	ages to the street or of or of		1 Burial 2 Cremation 3	Removal from State	emetery, crer	natory or other plac	'				,		
altimore,	it. Partmay		* 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Fig. 1) Seq. 1. Se	y) MI		REMATORY  Name and Addres	-	12-01	L-04	BAL	TIMORE,	MARYLANI	)
Ba	Department of the permitted of the permi		1/1900	xour	W	M C BROWN 21 S PHIL	COMM	'TINUI	FUNE	RAL ABER	HOME-HA DEEN, M	RFORD P	. A .
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not ent	er the mode of dyin	g, such as	cardiac or	respiratory	arrest,		Approximate Interval Betwee Onset and Dea	
	Pnysician	3 1	Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYD	CARDI	AL INFA	RCTI	ON_				DAYS	2(11
	/Medical- Examiner		resulting in death)	Due to (or as a conseq		1 . www. 400 anni anni anni	24						
	46	e	Sequentially list conditions, if any, leading to immediate	b. CORONARY		Y DISER	SE					YEARS	
17	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
o,	an andrial-tra	Exa	resulting in death) Last	Due to (or as a conseq	uence of):								
8760,	icate be executed physician and s the burial-transit	dical		d									
_	ertific ding p	/Mec	IF FEMALE:	23c. If yes, outcome of pregna	anov.								
Вох	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	Ectopic pregnancy Other (specify)					23d. Date of de Month	Day Yea	ar
o.	the de y the iched	ysic	1  Yes 2  No 9  Unknown	9□ Unknown	02.11	Other (specify)			-				
Δ.	s that ned b s deta	by PI	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause give	en in Part I		23e. Dic	l tobacco ι	use contribute t	o the cause of deat	th?
Records,	quires t an signe uld be	ed b	ACUTE RENAL FAIL	JRE					1 [	Yes 2	□No 3□P	robably 4 <b>X</b> Unk	nown
000	aw requir ts been si 2 should	Completed							24a. We	s an opsy		utopsy findings ava	
Ĕ	The lav	No.								formed?	death?	completion of caus	36 01
Vital	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?	200				of Death	(Check only	one)			
1	Physic this o	은	1 Yes 2 No		ER/Outpatien		4 🗆 140				6 ☐Other (Spe	ecify)	
Division of	Attanding Physician: r death. sctor: After this certificator, by the funeral director,	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	/at k? Yes 2.⊡		3d. Describe	now inju	ry occurred		
S	death death stor: / the f	icat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	e One Place of Leiung At h	ome larm str		162 7	-	Rf. Location	(Street an	nd Number or A	ural Route Number	r
<u>&gt;</u>	il or Attanı after deatl Diractor: d in by the	Certification;	4 Homicide determined	building, etc. (Specif	(y)	oot, 120tory, 011100				own, State		01471100107127780	
	To the Hospital or Attant within 24 hours after deatl To the Funeral Diractor: completely filled in by the	edical C	(Check only Z Medical Exa	nysician: To the best of my kno miner: On the basis of examina	owledge, death	n occurred at the time vestigation, in my of	ne, date an pinion, dea	d place, ar	nd due to th	e cause(s)	) and manner a d place, and du	s stated. e to the cause(s)	
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	e number			29d. Da	te signed (Mon	th. Dav. Year)	
)	Z × Z		· A	Helory 1	U.A					Nov	ember	29, 2004	
•	1		30. Name and address of person who				7695			, , , , ,		×1, ×104	<u>-</u>
	211						yeees 44.2						
	Sta	te	31. Date filed (Month Day Year)	32. Agistrar's Signa	ature	Carre	VE T	SWEU	4 Piril	KY LIPI	ND 212	4,5 4.3	
	Registr	ar	DEC 03 2	1004 Alexan	D A	3542							

			For State Registrar		State of	Marylar		artment rtificate			and M	ental Hyg	iene 0	04	38301
25	Physici /Medic			ge Jone	es							2. Date of Death Month	Day Der 15	Year 2004	3. Time of Death
7	Examin	er	4a. Facility Name (If not in Mercy Me			iber)				Location o imore	f Death		4c. Coun	y of Death	
	Funeral		5. Social Security Number	6. Se	(	7. Age (In yrs.	last birthday)	If Under	1 Year	if Under		8. Date of Birth (Month, Day,	Voorl	9. Birthr	place (State or Foreign
	Director		500-08-8568 Usual Residence of Dece		M 2□F	41	Yrs.	Months	Days	Hours	Min.	Sept 8,	1963	Coui	unk
	arylan show	_	10a. State 10b.	County		10c. Ci	ity, Town or Lo Balt:							1	10d. Inside City Limits
	28a-f	ecto	10e, Street and Number				Dail.	10f. Zip	Code			10	g. Citizen of	What Cour	1½ Yes 2 No
	h with	I D	311 E. 29t	h Stree	t			701. Esp	0000	2121	1.8		. O. (1201) O.	USA	inity:
ဟ	after deati or itams 2	Funeral Director	11. Marital Status 1 X Never Married 2		12. Was Dece Amed For 1  Yes	ces? 2 ⊟ No	unk			spanic Orig n, Mexican		cify Yes or No- Rican, etc.)		ce - Americ ack, White,	etc.
Ö 0 0	hours a tural', c	þ	3 Widowed 4 D		If Yes, Give Year or Da	tes:		1□ Yes 2		Specify:			Speci		black
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or itams 23a or 28a-f show marked other than "natural", or itams 23a or 28a-f show marked other than "natural".	Completed	(Specify online Elementary/Secondary unk		cation e <i>completed)</i> College (1- nk	4or 5+)	(Give	dent's Usua kind of won DO NOT us	k done d	luring most	of worki	ng unk 1	6b. Kind of E	Business/In	<sup>dustry</sup> unk
/land	uld be filed Mental Hyg Irked othe Itic avant.	To Be C	17. Father's Name (First,	Middle, Last)				uı	nk	18. Mothe	r's Name	(First, Middle, N	faiden Suma	me)	unk
Mary	12 sho		19a. Informant's Name/R									l Route Number,	City or Town	, State, Zip	Code)
Baltimore, I	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant. The Maritcal Examinations to be rediffied at ange.	9200	Mercy Medi  20a. Method of Dispositio  1	n mation 3 □P	emoval from S	State	301 S Place of Dispo cemetery, crei	sition (Nam	e of	1			10 21 Oc. Location		own, State
Baltir	permit. P Departme Importan any injur.		21. Signature of Euneral Rona			rycto		Name and State Balti	Addres Ana	s of Facility	Boan	655 W	. Balt	imore	Street
	Shysician /Medical	•	23a. Part 1. Enter the dissipance, or heart failu Immediate Cause (Final disease or condition resulting in death)	ease, or complied. List only or	e cause on ea	Ch line.	1 3		of dying		cardiac o				Approximate Interval Between Onset and Death
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	cuted nd ransit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	ité 🕇 .	Due to (d	or as a consec	quence of):								
3760,	cate be executed physician and the burial-transit	ical	resulting in death) Last		Due to (d	or as a consec	quence of):								
.O. Box 6	ath certifi ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregrin the past 12 month 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)	nam		th 2 ☐ Feta unt at time of o	aldeath 3 [	Ectopic pre Other (spe						ate of delive	ery Day Year
rds, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant	conditions cor	tributing to dea	ath but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did toba			ne cause of death?
	The law re- ate has bee page 2 sho	Completed										24a. Was an autopsy perform	ed?	prior to cor death?	psy findings available inpletion of cause of 2 No
Vita	ician: certific rector,	Be	25. Was case referred to examiner?		lospital:				Othe			Check onl one			1
Division of	or Attanding Physician: ifter death. Director: After this certific in by the funeral director.	tlon: To	1 Yes 2 No  27. Manner of Death 1. Natural 5	Pending	1 □ In 28a. Date of (Month		ER/Outpatien 28b. Time of Injury		lc. Injury Work	'' 4 □ Nur at ? 'es 2 □ N	2	ne 5 ☐ Resider 8d. Describe hov	v injury occur	ner <i>(Specif</i> ) red	hospice
Divisi	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:		Could not be determined	28e. Place o	of Injury - At h g, etc. <i>(Speci</i> l	ome, farm, str fy)				-	8f. Location (Stre City or Town,		ber or Rura	l Route Number,
	To tha Hospital within 24 hours a To tha Funeral I completely filled	edical	29a. Certifier 1.20 (Check only one)	Certifying Phys ledical Exami	sician: To the to ner: On the bas and manne	sis of <b>examin</b> a	owledge, death ation and/or in	n occurred a vestigation,	t the time	e, date and inion, deat	place, a	nd due to the cau d at the time, dat	use(s) and m se and place,	anner as st and due to	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of	certifier	^			29c.	License	number		29	d. Date signe	d (Month, I	Day, Year)
			▶ PN		00		- 00	7	241	2851	-	\	1/19	200	1
			30. Name and address of	Person who co		of death (Iter	5 - O	Print)	). (	2. 11	in:	WE W	d. 3	170	>
	Sta		31. Date filed (Month, Da	y, Year)	1	gistrar's Signa		8	Land I	إسلما	Er III	13 (		100	
•	Registr	ar	DEC 0	3 2004	Cie	Now I	for p	board	and the						

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MICHAEL Month Year KUCHERAVY THEODORE NOVEMBER-25- 2004 10:28 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CONTER HARBOR HOSPITAL BALTIMORB N/A 8. Date of Birth (Month, Day, Year) Feb. 14, 1934 If Under 1 Year | If Under 24 Hrs. 5. **21**a55a3047480 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** Days Hours XXM 2 F 70 Director 34-4893 Yrs Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits "neturel", or Items 23a or 28a-f shov adical Examiner must be notified at MD Director Anne Arundel Linthicum 1 Yes 2 XX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 816 White Avenue 21090 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after to ment of Health and Mental Hygiene.
ant: if item 27 is marked other then "neturel", or Iter any or other treumatic event, the Medical tearmine. Black, White, etc. 1 XXYes 2 No Army
If Yes, Give
Year or Dates: Unk. 1 ☐ Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Industrial Maint. Welder 17. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Walter Kucheravy 18. Mother's Name (First, Middle, Maiden Sumame) Helen Swirdowich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is eny injury or other tre once. Walter Scott Kucheravy/ Son 816 White Avenue, Linthicum Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 11/29/2004 Baltimore Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 21. Signature of Funeral Service Licensee Victor P. Doda, Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK **Physician** disease or condition resulting in death) 4 DAYS /Medical Due to (or as a consequence of) Examiner PNEUMONIA 10 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or). Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by page 2 should be NON HODGKINS LAMPHOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform rmed? 2X No 1 ☐ Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: investigation M 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 R BS NOVEMBER - 25-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARKANDAYA BALTIMORE MANJUNATH MD 21225 S. HANOVER STREET.

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

DEC 03 2004

32. Registrar's Signature

Bener

			For	riease			nd / Depa	artmer	nt of H	lealth and	Mental Hy	giene		
			1 - State Registrar				Cei	rtificat	e of l	Death		Reg. No	2004	38303
	Physici /Medic		1. Decedent's Name (File		Kyles						2. Date of De Month 11	Day 18	Year 04	7:47A M
	Examin		4a. Facility Name (If not			•		4b. City,	Town, or	Location of Deat	h	4c. (	County of Deatl	า
			Montgomery		al Hosp	ital			ney				ontgome	ry
	Funeral Director		5. Social Security Numb 422-12-635	7	x □M 2 🕮 F	7. Age (In yrs	. last birthday) Yrs.	If Under Months	Days	If Under 24 Hrs Hours Min.		th ly, <i>Year)</i> 21	9. Birth Co. Ala	nplace (State or Foreign untry) bama
	and *		Usual Residence of Dec	edent c. County		10c. C	ity, Town or Lo	cation					<del></del>	10d. Inside City Limits
	sho	ö		_										1√2 Yes 2 No
	28a-	Director	MD 1 10e. Street and Number	Montgom	ery	) 5	ilver S	10f. Zip				10a Citiz	zen of What Co	untry?
	with Ba or		13721 Town		bood				20906	i i			USA	y.
	heath rns 20	Funeral	11. Marital Status	I LILIE	12. Was Dec	edent Ever in l	J.S. 13.				Specify Yes or No to Rican, etc.)	- 1	14. Race - Amer	ncan Indian,
0	r Iteu		1 Never Married	2 Married	Armed For 1 ☐ Yes	2 👿 No					to Rican, etc.)		Black, White	
3	al', o	by	3 XWidowed 4 □	Divorced	If Yes, Gi Year or D	ve ates:		1 🗌 Yes	2 <b>⊠</b> No	Specify:			Specify: Bla	ck
0500-C	be filed within 72 hours after death with the Maryland Hygiene.  dother than "natural", or items 23a or 28a-f show id other than "natural", or items 23a or 28a-f show event, the Madhall Examiner ment he mailfied at	Completed	15. (Specify o	Decedent's Ed	ucation		16a. Dece	dent's Usu	al Occupa	ation	rkina	16b. Kir	nd of Business/l	ndustry
V	ithin ie.	nple	Elementary/Secondar		College (	1-4or 5+)	1			during most of wo )	iking	TT 0	0	
7	ygier ygier yar th	Co			4 yr	s.	Wr	iter	/Edit				. Gover	nment
a a a	ba d d	Be	17. Father's Name (First								me (First, Middle,		Sumame)	
<u> </u>	ould Men Marka	2	Thomas C.								Hatcher			
Mar	12 should ba filed within 1 h and Mental Hygiene. 7 is markad othar than "I traumatic event, the Med		19a. Informant's Name/	Relationship (7	ype, Print)		19b. Mailir	ng Address	S (Street a	and Number or Ri	ural Route Numb	er, City or	Town, State, Z	ip Code)
= ໜົ	ges 1 and 2 should t of Health and Men I fitem 27 is marka or other traumatic		Bobbie J.		Daughte	r	13721	Town	Lin	ne Road_	Silver S			
5	parmit. Pages 1 and Department of Healt Important: If item 2 any injury or other ance.		20a. Method of Dispositi 1 🔀 Burial 2 □ Cr	emation 3 🗌		State 200.	Place of Dispo cemetery, crer	natory or c	other plac	θ)	Date	20c. Loc	cation - City or	rown, State
bannore,	t. Pa tmen tant: njury		`4 □ Donation 5 □			Ar					)1-04		ington,	
0	Separ Mpor mpor iny ir		Arlington NAtional 12-01-04 Arlington, VA.  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011											
	40260		PM	acho	le								, D.C.	Approximate
		23a. Parth. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, of heart failure. List only one cause on each line.  Immediate Cause (Final												
	Physician		disease or condition resulting in death)	_		DREHA		STRO	KE					Onset and Death
	/Medical Examiner				Due to	(or as a conse	quence of):							,
		<u>.</u>	Sequentially list condition if any, leading to immediate. Enter Underlying	ons,	b	(or as a conse	oneuce of).							
	ted nsit	Examiner	Cause (Disease or injur	g y		(0	4							
	al-tra	хаі	that initiated events resulting in death) Last	- 1	c. Due to	(or as a conse	quence of):							
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000	ficate g phy as the				u									
Š	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pre	anant		tcome of pregr		1				2	3d. Date of deli-	very
Ō	death e atte d for	cia	in the past 12 mon 1 ☐ Yes 2 🛣 No	ths?	4☐Preg	oirth 2□Fet nant at time of		Ectopic pi Other <i>(sp</i>					Month	Day Year
,	t the by the acha	hys	9 🗆 Unknown		9□ Unkn	own	-							
r.	s tha	y P	Part II. Other significan	t conditions co	ontributing to d	eath but not re	sulting in the u	nderlying o	ause give	en in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
Splos	quire en sig uld b	Completed by	CORDHARY	ARTERY	DISER	re Re	THAL FI	Arcup	i .		1 🗆 '	res 2	No 3□Pro	bably 4 Unknown
၁ ၁	s bec	plet	HYPERTENS	. سرن	STROK	EIH	1337	SCHI.	2.0 12.	HREMIA	24a. Was		24b. Were aut	opsy findings available
ב	The It	mo	,		- 7 102.4						autor perfo	rmed?	death?	ompletion of cause of
	sician: The law s certificate has b lirector, page 2 s	0	25. Was case referred t							26. Place of Dea	ath (Check only o		12165	21300
>	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 No		Hospital: 1	Inpatient 2	ER/Outpatier	it 3□ D0	Othe		lome 5 ☐ Resid		□Other (Spec	ify)
ō	g Ph ter th neral		27. Manner of Death		28a. Date	of Injury th, Day Year)	28b. Time of	2	28c. Injury Work	at	28d. Describe I			,
2	Attendin death. ctor: Afi y the fur	atlo	2 Accident	Pending investigation		., Jay . oa ,	,,	М		Yes 2 □No				
DIVISION	r Atte er de racto by th	Certification;	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	288 Placi	of Injury · At h	nome, farm, str	eet, factor	y, office		28f. Location (S City or Tox		Number or Rui	ral Route Number,
5	rs aft al Di ed in	Cer	[i]			- J						, σ,		
	To the Hos, ital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ca	Check only 2	Certifying Ph Medical Exam	ysician: To the	best of my kn	owledge, death	occurred vestigation	at the tim	e, date and place	e, and due to the	cause(s) a	and manner as	stated.
	the I	eq	one)		and mar	ner stated.	(41.40 (11)							
	To To	Σ	29b. Signature and title	L)	1			29c. License number 29d. D					9d. Date signed (Month, Day, Year)	
	\		Dr. 40	*		نيا رو مد د			005	3542		NOV	18,20	104
	V		30. Name and address						الأفيد					
			31. Date filed (Month, D			S IS	WIE	374	[7]	101				
	Sta	ite 'ar		<b>n 3</b> 200	109	rogistial s Sign	La	16 1						

			1 - State of Registrar	Maryland / Depa	artment of F			ene <sub>g. No.</sub> 2004	38304						
	Physici		1. Decedent's Name (First, Middle, Last)  Thalia N. Kape	los	-		2. Date of Death	Day Year	3. Time of Death						
	/Medic	al	Thalia N. Kape  4a. Facility Name (If not institution, give street and num		4b. City. Town, o	r Location of Death	Decembe	4c. County of Deat	5:09 a M						
1	Examin	er	Good Samaritan Hospital	561)	Balti			n/a							
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign						
	Director		215-82-1739 Usual Residence of Decedent	Yrs.		<u>                                     </u>	April 15,	1916   Gre	ece						
	nyland how		10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits						
	8a-f s	Funeral Director	MD n/a	Baltimore					1 Y Yes 2 □ No						
	with the a or 2	D I	10e. Street and Number 501 Cedarcroft Rd.		10f. Zip Code 21212		10	g. Citizen of What Co Greece	ountry?						
	death ms 23	era	11. Marital Status 12. Was Dece	dent Ever in U.S. 13.		lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-	14. Race - Ame							
9	72 hours after death with the Maryland neturel; or Items 23a or 28a-f show lical Examiner must be notified at	/ Fur	1 Never Married 2 Married 1 Yes	2 🕱 No	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puerto I Specify:	Hican, etc.)	Black, Whit							
21215-0036	hours turel',	ed by	3 ☑ Widowed 4 ☐ Divorced Year or Da  15. Decedent's Education	tes:	dent's Usual Occup		1	6b. Kind of Business/	ite						
15	nin 72 n "ne M. dic	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1	(Give	kind of work done DO NOT use retired	during most of working)	ng '	OD. Kille of Desiriess	industry						
21,	filed within Hygiene.	Completed	o n/a	Ho	memaker			Own home							
Maryland		To Be	17. Father's Name (First, Middle, Last)  Nicholos Kalafat			18. Mother's Name Stella	(First, Middle, M	laiden Sumame) Unknown							
ary	2 should be and Mental is marked of eumetic eve	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	l Route Number,	City or Town, State, 2	Zip Code)						
	1 and 2 Health em 27 i		Constantine Sideris-son	501 20b. Place of Dispo		Rd., Baltim		1212	T C1-1-						
Jore	0°= 5			cemetery, crei	matory`or other plac	ce)		Moodlaum Man							
Baltimore,	orts		**************************************												
ä	Dep Imp	5 6	Mille	1		d Rd., Balt	imore, Md	21214	rici di rione						
	Pnysician /Medical Examiner	a h	23a. Part1. Enter the disease, or complications that control shock, or heart failure. List only one cause or elementate Cause (Final disease or condition resulting in death)  Due to (  Sequentially list conditions	or as a consequence of):	aren	L'al Mi	Jarie	Lin	Approximate interval Between Onset and Death						
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of): or as a contequence of):	Ban	mil	Z.J e	bleed	(/						
.O. Box 6	if the death certific. by the attending placehed for use as t	Physician/Medical	in the past 12 months?	ant at time of death 5	□Ectopic pregnancy □ Other (specify) _	1		23d. Date of del Month	ivery Day Year						
of Vital Records, P.	law requires that as been signed I 2 should be det	Completed by P	Part II. Other significant conditions contributing to de	ath but not resulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	24b. Were au							
al R			Jochunc	Gent (	liser		perform 1 Ves 2	ed! death? ☑No 1 ☐ Yes							
Vit	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ I	npatient 2 DER/Outpatier	nt 3 DOA Oth	26. Place of Death		nce 6 Other (Spe	o(h)						
		ı –	27. Manner eath 28a. Date	·		_	28d. Describe hov		city)						
Sior	Attending or death. ector: After by the fune	catic	2 Accident investigation		M 1	Yes 2 □ No									
Division	or Attendate death Director:	Certification:	determined e. Place	of Injury - At home, farm, sting, etc. (Specify)	reet, factory, office	2	28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,						
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the band mann	sis of examination and/or in											
	To th withir To th compl	Me	29b. Signature and title of certifier		29c. Licens	e number	29	d. Date signed (Monta	h, Day, Year)						
			14100000		VC	8318		Vec 2	2004						
	2		30. Name and address of person who completed caus  OPA  V  PAT  31. Date filed (Month, Day, Year)  32. R	2,00	Print) 70 3 BA	4-R	1 AM	CANA 2	1224						
	Sta Registi		DEC 0 3 2004	egistrar's Signature	Book	1									

			1 - For State Registrar	State of Ma	aryland /		artment rtificate			and M		giene Rag. NO	04	383	05
	n		Decedent's Name (First, Middle, Last	rt)	14.						2. Date of De	ath		3. Time of	
	Physici /Medi		Thelma		Kir	9	_				novembe		Day Year 3. Time of 200, 2004 3. Time of 200, 2004 11:3  4c. Country of Death  10d. Inside Country?  14. Race - American Indian, Black, White, etc.  Specify: Black  Kind of Business/Industry  14. Race - American Indian, Black, White, etc.  Specify: Black  Kind of Business/Industry  15. Approximate Chy School 16:00 Sumame)  16. Sumame)  17. State, Zip Code)  18. Approximate Interval Better Conset and Interval Better Conset	11:3	6 PM
	Examir		4a. Facility Name (If not institution, give		1		4b. City, To	wn, or	Location o	of Death		4c. Coun	ly of Death		
			Johns Hopkins Bayvieu  5. Social Security Number 6. S.			e i a te a te a d	If Under 1	inn	If Under:	24 Hrs	0.000		T = =:-		
ľ	Funeral Director		216 30 0750 1	M 22 F 7. A9	e (In yrs. last I	Yrs.		Days	Hours	Min.	8. Date of Bir Month, Da	y, Year)	9. Birth	place (State or intry)	Foreign
			Usual Residence of Decedent		<i>y</i> /		<u></u>				Andary	41156	26. 2004  4c. County of Death  4c. County of Death  9. Birthplace (State Country)  1936  10d. Inside Country?  14. Race - American Indian, Black, White, etc.  Specify: Black  3. Time of Country of Death  10d. Inside Country?  14. Race - American Indian, Black, White, etc.  Specify: Black  3. Time of Country of Death  10d. Inside Country?  14. Race - American Indian, Black, White, etc.  Specify: Black  3. Time of Country of Death  14. Race - American Indian, Black, White, etc.  Specify: Black  3. Time of Country of Death  14. Race - American Indian, Black, White, etc.  Specify: Black  3. Time of Country of Death  14. Race - American Indian, Black, White, etc.  Specify: Black  3. Time of Country of Death  14. Race - American Indian, Black, White, etc.  Specify: Black  3. Time of Country of Death  14. Race - American Indian, Black, White, etc.  Specify: Black  3. Time of Country of Death  15. Part of Country of Death  16. Country of Death  17. Specify: Black  18. Specify: Black  19. Specify: Black  19. Specify: Black  10. Specify: Bl		
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	with t	듬	10e. Street and Number	(0 10)	.12/		10f. Zip C	ode						ntry?	
	leath	Funeral	110 N. CENTRAL A	12. Was Decedent	Fyer in U.S.	13 1	Was Deceder	2/0	nanic Orio	nin? (Sn	acify Vac or No	-	• /	can Indian	
10	r Itan	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐	,				_	, Puerto	ecify Yes or No Rican, etc.)	Bla			
03	ours a	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes 20	LNO	Specify:			Speci	ty: B/	hele	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ither then "natural", or Itams 23a or 28a-f show ith: It e Medical Exertil at rrust be notified at	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16	a. Deced (Give	lent's Usual ( kind of work DO NOT use	Occupat done du	tion uring most	of worki	ing	16b. Kind of I	3usiness/Ir	dustry	
121	within ane. than	ld m	Elementary/Secondary (0-12)	College (1-4or 5	+)	0	,					21	. 0	6. 11.	/
d 2	d 2 should be filed within 72 h th and Mental Hygiene. 7 is markad other than "natu traumatic avant, IL & Medical		17. Father's Name (First, Middle, Last)	114		ع ر	CREAM	-	18. Mothe	r's Name	e (First, Middle,	DATHMI Maiden Suma	ne)	y school	
Maryland	ould ba Mental arkad c	To Be	BERNORD Smith						1		Dutto	/	/		
ary	2 should and Men is marka aumatic	-	19a. Informant's Name/Relationship (7	ype, Print)	19	b. Mailin	g Address (S					er, City or Town	ı, State, Ziç	Code)	
			TRACKY ROSS		3,	107	PARKION	21	WE :	Bartin	MUKE MAK	y knd	2/21.	3	
Baltimore,	of H of H if ita		20a. Method of Disposition  1→Burial 2 ☐ Cremation 3 ☐	Ramoval from State	20b. Place cemet	tery, cren	sition (Name natory or othe	er place	/ :						
Ë	Pa Int:		`4 □ Donation 5 □ Other (Specify	)	M4.310	IN C	EMETER	1_	/	12/2/	64	BAHMA	EMFA	yknd	
Ball	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licen	see		22	. Name and	ddress	of Facility	138,	As Funer	Al Hom			
	403 a 0		James Bles	liantiana that anyona	the death D	16	19 Ni	CA	RIVINO	5	+ BAK	HMORE M	1 Anylo	nd 31	23
B			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each lir	ine death. Do	o not ente	er the mode t	or ayıng.	, such as	cardiac c	or respiratory ai	rest,	14	Interval Betw Onset and De	reen
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8760,	death certificate ba executed e attending physician and od for use as the bunal-transit	dlcal		d											
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Вох	atten atten I for u	clan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal deat		Ectopic preg							*	ear .
0	that the di ed by the detached	hysi	1 ☐ Yes 2 Mo 9 ☐ Unknown	9□ Unknown			outer (open	.,,							
٣,	requires that the sen signed by th hould be detache	by P	Part II. Other significant conditions co	ntributing to death bu	it not resulting	in the un	derlying caus	se giver	in Part I.		23e. Did to	bacco use con	tribute to th	ne cause of de	ath?
ıd	v require baen sig should b	ed	chronic obstru	ictive pr	Imon	6100	dis	Reg	5.0.		1 🗆 Y	es 2□No	3 Prob	ably 4 🗆 Un	iknown
ecc	aw Is b	Completed	obstructive st	eep apn	ea, r	igh.	+ he	a	-		24a. Was autop		Were auto	psy findings av	vailable
- H	The ate h page	Con	failure	•		,					perfor	med2	death?		236 01
/ita	yaician: Th is certificate director, pag	Be	25. Was case referred to medical	11							(Check only o	/			
of	di S	2	1 Yes 2 No 27. Manner of Death		nt 2 ER/C	Outpatient Time of				sing Hor	ne 5 Resid	ence 6 Oth	er (Specifi	y)	
On	ding h. After funer	tlon	1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	Injury	28G.	lnjury a Work?	at es 2□N		zad. Describe n	ow injury occur	rea		
Division of Vital Records,	Attandil r death. actor: Al by the fu	fica	3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, i	farm, stre				-	28f. Location (S	treet and Numi	oer or Rura	l Route Numbe	e <i>r.</i>
Ö	al or A s after il Dira	Certification:	4  Homicide	building, etc	. (Specify)						City or Tow	n, State)			
	Hospital or Attanding 44 hours after death. Funaral Diractor: After tely filled in by the fune		29a. Certifier 1 Cartifying Phy (Check only 2 Medical Exam	sician: To the best of	f my knowledg	ge, death	occurred at I	he time	, date and	place, a	and due to the o	ause(s) and m	anner as st	ated.	
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	fedical	une)	and manner sta	examination a ted.	inavor inv				occurre					
	with To Con	Σ	29b. Signature and title of certifier  When	+1					number	0 0				,	
•								(C)	00			veremb	2- 21	6, LOC	24
	3		30. Name and address of person who o	600 No.	th wo	) (Type, F 1 <b>f</b> €	Street		Bultin	nove	Man	land	2128	7	
	Sta Registr	0.2	31. Date filed (Month, Day, Year)  DEC 0 3 2	32. Registra	r's Signature	B	An	n s							

			1 - For State Registrar	State of	of Maryla	nd / Depa	artment rtificate	t of H	ealth a Death	and M		giene ()	04	383	306
	Physici	an	1. Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath Day	Year	3. Time of	
	/Medic	al	Marjorie Kirby 4a. Facility Name (If not institution,		em hast		45 Cit. 7	Taura 05	Lasstian		Novembe	er 25,		2:50	РМ м
	Examin	er	Carroll County	_		a1.			Location on the results of the resul				rroll		
T	Funeral			6. Sex		s. last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	th V Yearl	9. Birth	place (State o	or Foreign
к	Director		216-03-1829	1□M 2∭F	85	Yrs.	Months	Days	Hours	MIII.	Oct 27,	1919	Eng	land	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. C	City, Town or Lo	ocation							10d. Inside C	ity Limits
	Mary I-f sh	to	MD Carr	·o11		Manch	ester							1 ☐ Yes	2 <b>X</b> No
	th the	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	intry?	
	ath wi	rai	3300 Kensington					21102				US			
	ter de	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	Armed F		U.S. 13.	Was Deced If Yes, spec	ent of His ify Cubar	spanic Ori n, Mexican	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)	- 14. Ra Bla	ce - Ameri ck, White	ican Indian, , etc.	
3	el', or	þ	3 XWidowed 4 ☐ Divorced	If Yes, G Year or I	VA	5-46	1 ☐ Yes 2	<b>X</b> I No	Specify:			Speci	<sup>fy:</sup> wh:	Lte	
9500-6121	filed within 72 hours after death with the Maryland Hygione. the than "naturel", or Items 23a or 28a-f show int, the Medical Exam and must be motified at	Completed	15. Decedent's (Specify only highest			16a. Dece	dent's Usua kind of word DO NOT us	l Occupa k done d	tion uring most	of worki	ng	16b. Kind of E	Business/Ir	ndustry	
2	within ene. than than	Jumo	Elementary/Secondary (0-12)	College	1-4or 5+)		oo not us urse	e retired)				heal	th		
מ מ	filed Hygin other ent, t	a l	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle,	Maiden Sumai			
<u>Iar</u>	wid be Menta arked artic ev	To B	Herbert Drake							Hei	nrietta	Catton			
Maryland 2	2 sho		19a. Informant's Name/Relationshin Robin Lee K									er, City or Town		o Code)	
ຄຸ -	1 and Healti em 27		20a. Method of Disposition	1109/5011	20b.	Place of Dispo	sition (Nam	ne of	1		ate	MD 211		own, State	
Ē	Pages ent of nt: If it ry or c		1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (Sp.		State	cemetery, crei	natory or ot	her place	9)				,	,	
Baltimore,	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked oth any injury or other treumatic event ODE.		21. Signature of Funeral Service L Ronald S	center /1	Directo	or S	Name and tate A	Anato	omy B	, oard 2120	655 W.	Baltin	nore	Street	
I			23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that	caused the de							rest,		Approximat Interval Bet	6
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	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):								1	
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Ď,	e exectian an	i Exa	resulting in death) Last		(or as a conse	equence of):									
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ВОХ Ф	certifi nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of preg							23d. Da	ate of deliv	erv	
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J.	res that the de signed by the a be detached f	Phy	9 ☐ Unknown  Part II. Other significant condition			aulting in the u	n doct inc. oo		n in Dard I		220 Did to	obacco use con	tributa to t	ha causa af s	looth?
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Vital	Physicien: this certific al director,	Be (	25. Was case referred to medical examiner?	1	/						(Check only of	ne)			
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	withi To t	Σ	29b. Signature and title of certified		_			License		. /		29d. Date signe			
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			30. Name and address of person w	A Reco	se or death (Ite	on zoa) (Type,	77 M	A-21A	hes.	10,	RJ IM	vovomb anches	40,	MAT	1102
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xamin	er	4a. Facility Name (If not institution, give Sinai Hospital	street and number)	ltimore	2_ 4b. C		Location of		y	N/a	ty of Death	
neral ector		5. Social Security Number 6. Se 218-12-4960 紫		ge (In yrs. last bi 93		der 1 Year Is Days	If Under 2 Hours	Min.	Date of Birth Month, Day, ary 24	Year) , 1911	Coun	olace (State or For otry) yland
fied at		Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimo	re		wn or Location						1	0d. Inside City Lit
or 288	Director	10e. Street and Number			10f.	Zip Code			1	0g. Citizen of	What Cour	ntry?
dian.		3632 Sussex Road				21207				United		
r, or items	by Funerai	11. Marital Status  1 Never Married 2 Married  Yel Widowed 4 Divorced	12. Was Decedent Armed Forces: 1 Yes 2 If Yes, Give Year or Dates:	? ] No		cedent of Hi pecify Cuba 2 XNo	ispanic Orig in, Mexican, Specify:	gin? (Specify , Puerto Rica	Yes or No- in, etc.)	Bla	ice - Americ ack, White, ify: Whi	etc.
marked other than "neturel, or nems 23a or 28e-1 snow imatic event, It's Medical Exentral tenculfied at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation	168	a. Decedent's U (Give kind of life. DO NO	work done d	during most	of working		16b. Kind of E		
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r other traumatic e	으	19a. Informant's Name/Relationship (T) Ronald T. Leavert	ype, Print)		9b. Mailing Addr 3 Delwo		and Number	r or Rural Ro	ute Number	City or Town	n, State, Zip	Code)
or other 1	Total Control	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Removal from State	20b. Place comete	of Disposition (I	Name of or other place	:e)	Date		20c. Location	- City or To	own, State
important: If its eny injury or o once.		<ul> <li>4 □ Donation 5 □ Other (Specify,</li> <li>21. Signature of Funeral Service Licens</li> </ul>	Balti	more Was			, -					Marylaı D <b>irector</b> :
eny i		James Q Kooose		00333								33-4784
ician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	_	nal F	- Cura							Interval Between Onset and Deat
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			1 - For State Registrar	State of N	/larylan		artment <i>tificate</i>			and Me	_	giene Reg. No	ひしゅ	38	30	8
I	Physici		Decedent's Name (First, Middle, Last)	Robert	Luca	s, Sr.					2. Date of De. Month	Da	y Year 9, 200	r	me of D	Death A <sup>M</sup>
>	/Medio Examir		4a. Facility Name (If not institution, give				4b. City,	Fown, or	Location of		NOVEIID		County of De		:25	A
-	Exami		5 Carver Road				Cai	bin	John				Montgo	mery		
	Funeral Director		5. Social Security Number 6. Sex 220-05-7095	7. A	Age (In yrs 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Bird (Month, Da May 16	h y, Year)	(	inthplace (S Country) Virgin		Foreign
	pu >		Usual Residence of Decedent  10a. State 10b. County		10a Cib	y, Town or Lo										
	shor	ក			100. 01									10d. Ins		/ Limits 2⊠ No
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	ms 2:	Funeral Director		12. Was Deceder		S. 13. V	Vas Deced			gin? (Spec	ify Yes or Noican, etc.)		14. Race - An		an,	
36	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "neturel," or items 23e or 28e-f show any in ury or other treumetic event, ite Medical Example at realise rodified at Once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces 1 ∑ Yes 2 ☐ If Yes, Give Year or Dates	] No		fYes,sp <i>ec</i> I⊡Yes 2		n, Mexican Specify:	, Puerto R	ican, etc.)		Specify: B			
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Maryland 21215-0036	12 sh h and 7 is n treun	i i	19a. Informant's Name/Relationship (Ty) Jonnie Lucas/Son	oe, Print)									r Town, State,			
ė,	1 and Healt em 2	1	20a. Method of Disposition		20b. P	lace of Dispos	sition (Nam	e of		ay, G	-		g, MD 2		te.	
Baltimore,	ages ant of it: If it y or o		1 ⊠ Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	emoval from Stat	e Ar	emetery, cren Lingtoi	natory or oth	her place Lona	T E	eceml)	ber7,		,			i a
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ļ			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cause se cause on each	ed the death line.	n. Do not ente	er the mode	of dying	g, such as	cardiac or	respiratory ar	rest,			kimate Il Betwe and De	
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<u>~</u>	The tate his page	Con									perfor	med? 2⊠ No	death?	s 2 No		
Zita Zita	yeiclen: Th	Be	25. Was case referred to medical examiner?					Lau		of Death	Check onl o	ne				
of	d o d	- To	1 ☑ Yes 2 ☐ No	ospital: 1   Inpat		ER/Outpatient			4 🗆 Nui	12 12 11 12			Other (Spi	ecity)		
on	ding Ph h. After th funeral	tlon	1 Matural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time of Injury	M 28	c. Injury Work	at ? ′es 2 □ N		d. Describe h	ow injury	y occurred			
ls.	l or Attenc after death Director: in by the	fica	3 Suicide 6 Could not be	28e. Place of Ir	njury - At ho	me, farm, stre					f. Location (S	treet and	d Number or F	ural Route	Numbe	er.
2	el or safter	Certification:	4 Homicide		etc." (Specify		,				City or Tow	n, State,	)			
	To the Hospitel or Ai within 24 hours after of To the Funerel Direc completely filled in by	edical C	29a. Certifier 11X Certifying Phys (Check only one)	ician: To the bes er: On the basis and manner s	of examinat	wledge, death ion and/or inv	оссипеd a estigation, i	t the tim in my op	e, date and inion, deat	d place, an h occurred	d due to the c at the time, c	ause(s) late and	and manner a place, and du	s stated. e to the cau	se(s)	
	Vithin Vithin To the	Me	29b. Signature and title of certifier				29c.	License	number		2	29d. Date	e signed (Mon	th, Day, Yes	a <i>r)</i>	
	\		Thorax P.		1-			20	69	59	/	voi	rembe	29	,20	204
1	11,		30 Name and address of person who co	mpleted cause of	death (Item	23a) (Type, F										
	,			STINE		D.	8808	+	MDE	N Hz	uce	SAL	- Po	DUA	ic,	MO
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 3 2004.	32. Regis	trar's Signat	y de	parks						j	20	185	7

			1 - For State Registrar	e of Maryland / Depa	artment of Health and tificate of Death	•	700L 38309
	Physici		1. Decedent's Name (First, Middle, Last)  RICHARD MALONE			2. Date of Death Month	Day Year 3. Time of Death
	/Medio Examin	er	4a. Fecility Name (If not institution, give street an		4b. City, Town, or Location of D	Death	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 153. 16. \$146 174 20	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birth (Month, Day, Ye	ar) 9. Birthplace (State or Foreign Country) VA
	yland how		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	^*		10d. Inside City Limits
	th the Ma or 28a-f s e notified	Funeral Director	MD HOWARD  10e. Street and Number	Ellicot	10f. Zip Code		1 □ Yes 2 🕱 No  Citizen of What Country?
	death wi	nerai 🛚	8418 GOVERNOVS RUK 11. Marital Status 12. Was		2 0 4 2 Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, P		14. Race - American Indian, Black, White, etc.
9000	ours after ral', or ite	ğ	1 Never Married 2 Married 1 1 1f Ye	res 2√2TNo	1 ☐ Yes 2 🖾 No Specify:	dono mean, etc.)	Specify: BLACK
1215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show he Modical Exemiter must be notified at	Completed		ge (1-4or 5+) (Give life.	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working	. Kind of Business/Industry  RETA L
and 21	ould be filed with Mental Hygiene arked other the atic event, the	Be	12th grade 24 17. Father's Name (First, Middle, Last) Leonard Malone	ears	18. Mother's	Name (First, Middle, Maid	den Sumame)
Maryland	d 2 should th and Men 7 Is marke treumatic	٦ ر	19a. Informant's Name/Relationship (Type, Print		ng Address (Street and Number o		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if item 27 is marked other then "natural", or items 23s or 28s-1 show any injury or other treumatic event, the Medical Examinat must be pufflied at DDGs.		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal	20b. Place of Dispo	sition (Name of	Date 20c	a Midtsville, MD
Baltimore,	permit. Pag Department Importent: any injury c		21. Signature of Funeral Service Licens  2 august		. Name and Address of Facility	eene FUN	ERAL SERVICES (E. BALTO, MD 21229
			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause Immediate Cause (Final	hat caused the death. Do not ent on each line.			Approximate Interval Between Onset and Death
	Physician /Medical Examiner			e to (or as a consequence of):			
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Unestee or any that initiated events c.	e to (or as a consequence of):			
68760,	te be exec ysician an e burial-tr	icai Exa	annulaine in density to as	e to (or as a consequence of):			
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medi	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
Δ.,	ires that t signed by d be detad	by Ph	Part II. Other significant conditions contributing		nderlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
Records,	e law requir has been si je 2 should	Completed	CEREBROVASCULAR AC			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of
Vital F		Be Co	25. Was case referred to medical examiner?			1 ☐ Yes 2 ☐ Death (Check only one)	
of	g Physicien: ler this certific neral director,	n: To		1 ✓ npatient 2 ☐ ER/Outpatier Date of Injury Month, Day Year) 28b. Time of Injury		ng Home 5 Residence 28d. Describe how in	
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation	Place of Injury - At home, farm, str building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St	and Number or Rural Route Number,
D	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: T	o the best of my knowledge, death	occurred at the time, date and p	lace, and due to the cause	
	To the Hospital within 24 hours a To the Funerel Completely filled	Medicai	29b. Signature and title of certifier	manner stated.	29c. License number		Date signed (Month, Day, Year)
	1		30. Name any address of person was empleted	cause of death (Item 23a) (Type.	/ 10021	NOV	EMBER 30, 2004
	Sta	ite	KIMBERLY WALLACE 31. Date filed (Month) Day, Year)	22 SOUTH GF 32. Registrar's Signature	·	ACTIMORE, 1	UD 21201
DH	Registr		DEC 0 3 2004	Beneva &	frak		
				ORIGINA	12000		

		-	For State Registrar	State of Maryla	nd / Depa	artment of H	lealth an Death		Reg. No.	38310
	Physicia		1. Decedent's Name (First, Middle, I Betty A.	Aast) Mihialovici				2. Date of Dea Month Decembe	Dav Year	3. Time of Death 11:34 P M
	/Medic Examin		4a. Facility Name (If not institution, g	rive street and number)	···	4b. City, Town, or		Death	4c. County of Dea	ath
	Funeral		North Arundel H 5. Social Security Number 6.	IOSP1T&I .Sex 7. Age (In yrs	. last birthday)	If Under 1 Year		Hrs. 8. Date of Birt	th 9. Bi	rthplace (State or Foreign ountry)
	Director		219-10-4952 Usual Residence of Decedent	1 ☐ M 2 💢 F	80 Yrs.	Months Days	Hours	April 1	<sup>y</sup> 3 <sup>Y</sup> 924	MD MD
	ryland show	_	10a. State 10b. County	10c. C	ity. Town or Lo					10d. Inside City Limits
	the Ma	ecto	Maryland Anne A	rundel		Pas 10f. Zip Code	sadena		10g. Citizen of What C	1 Tes 2 No
	23a or	al DI	31 Fallon Driv	'e			21122		USA	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic avent, the Medical Examiner must be redilled at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No		i? (Specify Yes or No- Puerto Rican, etc.)		
15-0	"natur edical	Completed	15. Decedent's (Specify only highest of		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of	f working	16b. Kind of Business	s/Industry
212	e filed within al Hygiene. other than ' vant, me Me	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)		Bar Maid			Tavern	
Baltimore, Maryland 21215-0036	td be file ental Hy ked oth ic avant	Be	17. Father's Name (First, Middle, La William E.	st) Wood			18. Mother's	Name (First, Middle, May Fo	Maiden Sumame) OX	
lary	2 should be and Mental la marked c	2	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street	and Number o		er, City or Town, State,	Zip Code)
re, N	is 1 and 2 of Health a itam 27 is other train		Renee Crispens 20a. Method of Disposition	(daughter)	31 Place of Dispo	Fallon Dr psition (Name of matory or other place		Pasadena, I ec. <sup>Date</sup> 03	MD 21122 20c. Location - City o	r Town, State
imo	Pages ment of ant: If ii ury or o		1 ☐ Burial 2 【X Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe			ematory I		2004	Baltimore,	Maryland
Balt	permit. Pages 1 Department of H Important: If its any injury or ot once.		21. Signature of Fuperal Service L	9 11			ıntain	Road, Pasa	gs Funeral adena, MD 2	21122
ı			23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final							Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)	a	QUETICE of):	CAIL	.0 , 0 M	GOPATA	4	
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ISC	u. Bm i	A OF	LEF	T LEG.	•	
	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse	raugas of):			-		
8760,	cate be executed physician and the burial-transit			d						
.O. Box 68	the death certifi y the attending ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal déath 3[	□Ectopic pregnancy	,		23d. Date of de Month	olivery Day Year
Δ.	law requires that as been signed by 2 should be deta	by	Part II. Other significant conditions	s contributing to death but not re	sulting in the u	underlying cause giv	en in Part I.		obacco use contribute Yes 2□No 3□F	to the cause of death? Probably 4 Dunknown
Vital Records,	The ate has page	Completed							osy prior to death?	utopsy findings available completion of cause of s
Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	at 3 DOA Oth		Death (Check only o	one) dence 6 □Other (Spi	ocifu)
on of	ding h. After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur Wor	y at	28d. Describe h	how injury occurred	outy)
Division	or At fter c Sirac in by	Certification;	3 Suicide 6 Could no 4 Homicide determine		home, farm, st	reet, factory, office		28f. Location (S City or Tov	Street and Number or F wn, State)	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by	edical (		Physician: To the best of my kr kaminer: On the basis of examin and manner stated.						
١	withi To 1	W	29b. Signature and title of pertifier			29c. Licens			29d. Date signed (Mon	nth, Day, Year)
,	\		30. Name and address of person wh			, Print)	0557		12/1/0	7
			S. Berhone M.D.			Glen Bur	rnie, M	1D 21061		
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 3 201	04 Sperse	B	Booker	,			

				State of Maryland / Department of Health and N  1- State Registrer Certificate of Death		iene 2004	38311
				Decedent's Name (First, Middle, Last)	2. Date of Deat	th	3. Time of Death
		Physicia /Medic		MABEL. M. MACGREGOR	Nouth	23 2004	1145P M
		Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of Death	•
				5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	9 Date of Righ		olace (State or Foreign
		Funeral Director		220 - 07 - 2232 1 M 22 F 87 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, AUG- 4	Year) Cou	ntry) MD
				Usual Residence of Decedent			10d Incide City Limite
		shov	ū	10a. State 10b. County 10c. City, Town or Location PARKULLE			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
		death with the Maryland vms 23e or 28e-f show ir must be notified at	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cou	
		h with		3213 Orlando Ave 21234		U.S.	A.
		ems ?	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Start of Hispanic Origin)	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
	36	rs afte	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:		Specify: Lu	nite
	9	filed within 72 hours after death w Hygiene. other then "naturel", or Items 23e ent. I'm Medical Examiner must b		15. Decedent's Education 16a. Decedent's Usual Occupation	<i></i>	16b. Kind of Business/Ir	
	215	thin 7.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  A S S EM (3 L y L (			6
	121	iled witygien tygien her th		70(1.	ne (First, Middle, I	MARTIN N	MARIETA
	anc	d be fi	To Be		+ WR'14		
	Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla to G Health and Mental Hyglene. If Hem 27 Is marked other then "naturel; or Hems 23e or 28e-f show or other treumatic event. In Medical Examinat must be notified at	F	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			c Code)
	N	and 2 salth a n 27 ls		KAREN Weber 3213 OFFANDO AVE 1			
	Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other tree		Thurse 2 Cremation 3 Removal from State   cemetery, crematory or other place)	Date 0 04	20c. Location - City or To	
۶	Ē	urtmen urtmen ortent: njury				Bolto. M.	
2	Ва	Depar Impor any ir		21. Signifure Funeral Service Licensee  22. Name and Address of Facility 57  10. LL M. Stells  23. Name and Address of Facility 57  10. LL M. LLCR - 57  10. LLCR - 7527 has Feed Ro.	Bolto 1	NO 21234	
7.				23a. Parv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition resulting in death)  a. Sepsis syndrome  Due to (or as a consequence of):			Onset and Death
7		/Medical Examiner		Due to (or as a bonsequence of):	tract w	Tection	(1)-00101
23/04			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		7	00 0-1
4 h	/	nd nd transit	Examiner	that initiated events c.			
Angella .	8760,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
_	687	certificate be executed Iding physician and Ise as the burial-transit	edical	d			
be	Вох	h certi ending use a	m/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of deliv	,
mabe	. B	iaw requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/Me	in the past 12 months?  1		Month	Day Year
~	P.O.	requires that the leen signed by th hould be detache		Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	pacco use contribute to t	he cause of death?
00	rds,	quires n sign ald be	d by	Dementia	1 □ Ye	as 2 No 3 Prol	bably 4 []Unknown
actinegor	000	law rec as bee	Completed	Coverny Artery disease	24a. Was a	n 24b. Were auto	opsy findings available impletion of cause of
4	Ä	iicien: The lav certificate has rector, page 2	Com	multiple strokes	perform	med?   death?	2 □ No
3	Vita	icien: sertific ector,	Be	examiner?	ith (Check only on		11 -
5	of	Phys r this aral dir	1: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Reside	ence 6 XOther (Special power of the control of the	M) Hospice
	ion	nding ath. r: Afte e fune	atlor	Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
	Division of Vital Records,	or Atterde	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town	reet and Number or Run n, State)	al Route Number,
	Ω	pitel o		Zea. Certifier Tix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	and rule ve the re	aireare) and man iar as a	(rafan)
		To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence)	rred at the time, d	ate and place, and due t	o the cause(s)
		withir To the comp	¥	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Month,	Day, Year)
		. 10		1 / Hrshay Mily, and Des 205	/	VO ventile.	-T,200x
		12		30. Name and address of person who completed cau death (Item 23a) (Type, Print)  1. A. R. Zey G. 317 C. 670 ( N. Charles St.	Balto.	md 2120	>
		Sta	ate	31. Date filed (Month, Day, Year) , 32. Registrar's Signature			
		Registi	rar	DEC 0 3 2004 Send to Sparker			

		-	State of Maryla  State of Maryla		artment of F		_	giene 004	38312
	ာ		Decedent's Name (First, Middle, Last)				2. Date of De	ath	3. Time of Death
	Physicia /Medic	al -	John Charles Martino, Sr.				Novemb	er 29, 200	
	Examin	er	4a. Facility Name (If not institution, give street and number) 800 May Court		4b. City, Town, o			4c. County of De Harfo	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 213-26-5949 X 75	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bin Min. (Month, Da April	y, Year)	irthplace (State or Foreign Country) aryland
	pug *		Usual Residence of Decedent  10a. State 10b. County 10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	Maryia	tor	Md. Harford		Bel A	ir			Y Yes 2 No
	with the 3a or 28a at be not	Il Director	10e. Street and Number 800 May Court		10f. Zip Code 2	1014		10g. Citizen of What U.S.A.	Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic avant, the Modical Examinat must be notified at angle.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes 25 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 No		in? (Specify Yes or No Puerto Rican, etc.)	14. Race - Ar Black, WI Specify: W	
Maryland 21215-0036	vithin 72 hou ne. han "nature na dical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of working	16b. Kind of Busines	·
9	filed v Hygie other t	O a	12 years 17. Father's Name (First, Middle, Last)	owr	ier	18. Mother	's Name (First, Middle	restaur Maiden Sumame)	anc
lan/	uld be Mental rrked c	To Be	Biase Martino			Ant	oinette El	etto	
Mary	nd 2 sho alth and h 27 is ma ir trauma	8	19a. Informant's Name/Relationship ( <i>Type, Print</i> ) Tina Hartner/daughter				or Rural Route Numb ok Drive,		
altimore,	ages 1 a ant of Hea nt: If itam y or otha				osition (Name of matory or other pla Iem. Gdns		Date 2/02/2004	Bel Air,	
Baltir	permit. F Departme Importen any injur		21. Signature of Funeral Service Licensee		2. Name and Addre Schimune	ss of Facility k Fune	ral Home o		
	Pnysician		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition		ter the mode of dyir	ng, such as c			Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate  List only one cause on each line.  Due to (or as a consider one cause on each line.)  Due to (or as a consider one cause on each line.)	equence of): Hype	Heusion	9			10 425
7	ecuted ind transit	Examiner	cause. Enter Orderlying Cause (Disease or injury that initiated events	Dias	se tes				10 4 125
8760,	icate be executed physician and s the burial-transit	dical Ex	Due to (or as a const	aquence or):					
P.O. Box 6	ath certif attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknow	etal death 3	⊒Ectopic pregnanc □ Other (specify)	у		23d. Date of o	delivery Day Year
	ires that the de signed by the d be detached	by	Part II. Other significant conditions contributing to death but not r	esulting in the (	underlying cause giv	ven in Part I.	23e. Did t		to the cause of death?  Probably 4 □Unknown
Vital Records,	he faw requir e has been si age 2 should	Completed					24a. Was auto perfo	psy prior t prmed? death	autopsy findings available o completion of cause of ?es 2 \( \) No
ital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical			26. Place	of Death (Check only		2010
	ding Physician: The In. After this certificate ha funeral director, page	은	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2		III JU DOX		sing Home 5 A si		овсіfу)
ouo	ding P. h. After I	tlon:	27. Manner of Death  1☑ Natural 5 □ Pending 2 □ Accident investigation	28b. Time o Injury	Wo	ryat rk? ]Yes 2 □ N		how injury occurred	
Division of	I or Attanding after death. Diractor: Afte I in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, si cify)	treet, factory, office		28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
_	lospital t hours unaral	edical Ce	29a. Certifier (Check only one)  29 Medical Examiner: On the basis of examinant and manner stated.						
	To tha h within 24 To tha F	Med	29b. Signature and title of certifier	>	29c. Licen:	se number	C/9	29d. Date signed (Mo	onth, Day, Year)
,	17		30. Name and address of person who completed cause of death (II	tem 23a) (Type	Print)	30.10.	n Rd i	Follotoni	MD 2004
	Sta	ate	31. Date filed (Month Day, Year) 32. Aegistrar's Sig		Sparks		', /	-cus ion	
ė.	Regist		DEC 0 3 2004	P	pyround				

State of Maryland / Department of Health and Mental Hygiene 0 4 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 27, 2004 3:52 a <sup>M</sup> Robert Malone November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Months 1□ M 2□ F 1949 Director 146-40-5535 55 July 4, New Jersey Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State f show r then "naturel", or iteme 23a or 28e-f ehov the Medical Examinar must be notified at Edgewood Md. Harford 1 ☐ Yes 2 🖾 No Director 10f. Zip Code 10g. Cilizen of What Country? 10e. Street and Number 1725 Harbinger Trail 21040 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1☐ Yes 2☐ No Baltimore, Maryland 21215-0036 Specify: Specify: black Ď 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Importent: if item 27 ie marked other then "nt any mjury or other treumatic event, the Medit once. Elementary/Secondary (0-12) College (1-4or 5+) truck driver distribution 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessie Malone Lucille Villiarin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Malone/wife 1725 Harbinger Trail, Edgewood, Md. 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12/1/2004 Bel Air Mem. Gdns. Bel Air, Md. `4 ☐Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, T, Md. 2 101/2 ximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Cardiac arrest /Medical Due to (or as a consequence of): Examiner 5 years Cardiomyopathy Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of Examine Type 2 diabetes 2 years nding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, requires that the death certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by i should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2X No of or Attending Physician: after death.

Director: After this certifications 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 🗵 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 Director: After this d in by the funeral d 28c. Injury at Work? 28a. Dale of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospitel o within 24 hours af To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and mapper stated. 29c. License number 29b. Signature and title of certified Riverside Parkway 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) £1154 be +h Tilleros 1321 Belcamper MI isabeth 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 3 2004

		•	For State Registrar		State	e of Ma	aryland	d / Depa <i>Cei</i>	artmen rtificate	t of H e of L	ealth a Death	and M	ental Hy	giene Reg. No	-	3	88314
	Division		1. Decedent's Name (	First, Middl	e, Last)			-					2. Date of De Month	aath Dav	y Yea	ar	3. Time of Death
	Physicia /Medic		Barbara		An	n		Mec	k				Novemb				5:10 p <sup>M</sup>
	Examin		4a. Facility Name (If n	ot institution	n, give street and	d number)			4b. City,	Town, or	Location of	of Death		4c.	County of D	eath	
			Laurel R	egion	al Hosp	ital				ure1					rince		
	Funeral		5. Social Security Nun		6. Sex 1 ☐ M 2 🔀			ist birthday)	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da May 12	th ay Year)			ice (State or Foreign y)
	Director		577-50-4			<u> </u>	69	Yrs.					May 12	, 19	35 Wa	shi	ngton, DC
	and *		Usual Residence of D 10a. State 1	Ob. County			10c. City,	Town or Lo	cation							10	d. Inside City Limits
	Manyl 1 sho	ō	MD	Anne	Arunde1		C	rofto	n								1 ☐ Yes 2X No
	the t	ect	10e. Street and Numb						10f. Zip	Code				10a. Cit	izen of What	Counti	v?
	with Sa or		1736 May		Place					2111	4				USA		
	Jeath Ins 23	era	11. Marital Status		12. Was		Ever in U.S	3. 13.	Was Decec	dent of Hi	spanic Ori	gin? (Spe	city Yes or No	<b>D-</b>	14. Race - A	m erica	
98	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglens. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, If a Medical Exaction of the notified at	y Funeral Director	1 Never Married		ned 1 🗆 Y	d Forces? ∕es 2 <b>2∑1∕1</b> s, G <u>i</u> ve	No		lfYes,spex 1 □ Yes :	city Cuba	n, Mexicar Specify:	i, Puerto I	Rican, etc.)		Black, W Specify:		ite
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2	e filed within al Hygiene. i othar than vent, ir a Me		17. Father's Name (Fi	rst, Middle,	Last)						18. Mothe	er's Name	(First, Middle	<del></del>		- P	
Maryland	2 should be t and Mental I is marked of raumatic eve	Be C	John E.	Gille	spie. J	r.					Ms	rtle	Har1e	v			
$\mathbf{Z}$	mari mati	မ	19a, Informant's Nam		_			19b. Mailir	ng Address	(Street a			l Route Numb		or Town, State	e, Zip (	Code)
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2	ages ont of it: If i		1 X Burial 2 ☐ `4 ☐ Donation 5			rom State		metery, crei			- 1	2/4/	2004	Dave	idsonv	411	o MD
Baltimore,	artme ortan injur		21. Signature of Eune			1/	цаке		2. Name an	d Addres	s of Facilit	ty			TUSOIIV	TII	e, m
Ba	permit. Pages 'Department of H important: If ite any injury or ot once.		> bath	ch	A do	41			Hard 12 R	esty idge	Fune	eral Zenue	Home, Anna	P.A. poli	s, MD	214	01
П			23a. Part1. Enter the shock, or heart	disease of	r complications to	hat caused on each lir	the death.	. Do not ent	er the mod	le of dyin	g, such as	cardiac o	r respiratory a	rrest,		1	Approximate Interval Between
	Enysician-		Immediate Cause (Fi	nal		Met	astat	ic Ca	ncer							'	Onset and Death
	/Medical		resulting in death)		aDu	e to (or as	a consequ	ence of):								$\top$	
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9	ing p		IF FEMALE:														
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oro	w requir been sl should	Completed	Hypere	CHBIC	711								:	103 2			
ec	law las b	npie											24a. Was	DSV	prior	to com	sy findings available pletion of cause of
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	ding P h. After I funera	i o	27. Manner of Death  1 Natural	5 🗌 Pendii	28a. [	Date of Inju Month, Da	y Year)	28b. Time o Injury		28c. Injury Work			28d. Describe	how injui	ry occurred		
Sio	tendi eath ior: /	cati	2 Accident 3 Suicide	investi	not he				М		res 2□		30/ 1	· · ·	111 1		
Division	or Ati	Certification;	4 Homicide	detern	ningd 288. I	Place of Injouilding, et	ury - At hor c. <i>(Specify)</i>	me, farm, sti )	eet, factory	y, office		- 11	City or To			Hurai	Route Number,
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	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical			ng Physician: T Examiner: On t and		f examinati										
	o the	Me	29b. Signature and til	tle of gertifie		0 1	Mari		1 0		number			29d. Da	te signed (M	onth, D	ay, Year)
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	Ŋ		Deep Kul							ve,	#221	, Lau	rel, M	D 20	707		
	Sta	te	31. Date filed (Month														
	Registi		DEC	032	004	See July of	1.	Local	Ce de								

			For State Registrar	State of M	laryland / Depa Ce	artment of H			giene,	004	38315
	•	7	Decedent's Name (First, Middle)	, Last)				2. Date of Dea	ath		3. Time of Death
	Physicia /Medic		ARON			MERK	IN	Novemb			I
	Examin	er	4a. Fecility Name (If not institution		timore	Balty		ath C	4c. C	ourity of Death	
¥.	Funeral	ů:	5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hr	S. 8. Date of Birt	h Vaar)	N/A 9. Birth	place (State or Foreign
	Director		215-98-6545	1 <b>∆</b> M 2□F	75 Yrs.	Months Days	Hours Mir	03/11/1	929	Cou	UKRAINE
	land ow	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	n the Maryland r 28e-f show notified	ctor	MD I	N/A	BALTIM	ORE					1√ Yes 2 No
	vith the	Dire	10e. Street and Number			10f. Zip Code				n of What Cou	intry?
	death with the Maryland ms 23e or 28e-f show	Funeral Director	3615 FORDS LANI	12. Was Deceden	t Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (	Specify Yes or No-		RAINE . Race - Ameri	
2-0036	or Ita	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces ied 1 Tyes 2 If Yes, Give Year or Dates	] No	If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	irro Rican, etc.)		Black, White, pecify:	, etc. HITE
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nd 2	2 should be filed within and Mental Hygiene. is markad other than aumatic avant. Ite M	Be C	17. Father's Name (First, Middle,	Last)				ame (First, Middle,			
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Jre,	es 1 and 2 of Health f itam 27 i	1	20a. Method of Disposition  1		20b. Place of Dispo			Date		ation - City or T	
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Bal	permit. Pages Department of Important; If i any injury or one		21. Signature of Funeral Service	Licensee		2. Name and Addres					
	40.00		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death. Do not en					, ille,	Approximate Interval Between
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8760,	cian cian buria	ical Ex	resulting in death) Last	Due to (or a	s a consequence of):						
687	the Cat	Pa		d							201110
Вох	eath certific attending p I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1□Live birth		⊒Ectopic pregnancy	,		23	d. Date of deliv	very Day Year
	he dea the at	ysici	1 Yes 2 No	4□Pregnant 9□Unknown		Other (specify)				WOTEN.	24,
, P.O	The law requires that the death certifi tte has been signed by the attending page 2 should be detached for use as	by Ph	Part II. Other significant condition	ons contributing to death	but not resulting in the o	underlying cause giv	en in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
Records,	w require: been sig should b							1 🗆 1	/es 2□	No 3 Pro	bably 4 Unknown
Seco	e 2 sh	Completed						24a. Was autop	SV	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
Vital F		e Col	25. Was case referred to medica				GC Place of D	1 ☐ Yes	rmed? 2 No	1 🗆 Yes	21 No
ίV	Phyaicia this cert al direct	To B	examiner?	Hospital: 1 Inpa	tient 2 ER/Outpatie	nt 3 DOA Oth	OF	Home 5 ☐ Resid		□Other (Speci	ify)
n of	ding Ph After th funeral		27. Manner of Death 1 Natural 5 □ Pendir		jury 28b. Time o Day Year) Injury	Wor		28d. Describe	now injury	occurred	
Division	Attandi death. ctor; A y the fu	Certification:	2 Accident investi 3 Suicide 6 Could	not be	njury - At home, farm, st		Yes 2 □ No			Number or Rur	ral Route Number,
Ω	el or A	Sertii	4 ☐ Homicide determ	building,	etc. (Specify)	,,,,,,,		City or Tov	vn, State)		
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funaral Director; After this certifical completely filled in by the funeral director,	edical (	29a. Certifier 1 Certifyin (Check only one) 1 Medical	ig Physician: To the bes Examiner: On the basis and manner		th occurred at the tin evestigation, in my o	me, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) a date and p	nd manner as s lace, and due t	stated. to the cause(s)
	To tha within 2 To tha comple	Ž	29b. Signature and title of certifie			29c. Licens	e number	11		signed (Month,	
			30 Name and discount	who completed cause of	death (Item 22a) /Turn	Print)	5-4	99	Vove	enber	30,2004
			30. Name and address of person	M)	Sina,	Hospita	Lof	Balt Ima	-6		
(L)	Sta		31. Date filed (Month, Day, Year,		strar's Signature						
DIA	Regist	2	DLC (	3 2004	we st of	10042					

**ORIGINAL** 

		•	For State Registrar	State of M	larylan		artment of F rtificate of	Health and N Death		iene 0 (	) 4	38316
			Decedent's Name (First, Middle, Last)						2. Date of Dea	th	V	3. Time of Death
	Physici /Medic		DORIS		J.		MITCHEL	L	Novem 6	Day 00, 30, 2	904 004	1506 M
	Examin		4a. Facility Name (If not institution, give s	1 1 1			4b. City, Town, o	or Location of Death		4c. County	of Death	D1 / 6
			St. Hanes He		are	last hirthday	Ba (+1	More 14 Hrs.	R Date of Birth		0 Right	N/A
	Funeral Director		5. Social Security Number 6. Sex 212-30-7691	M 200 F	.ge ( <i>iii yis.</i> 1	ast birthday Yrs.	Months Days	Hours Min.	3. Date of Birth JUL . 28	1°933	Cou	place (State or Foreign ntry) VA
			Usual Residence of Decedent									
	anylan how	_	10a. State 10b. County		10c. City	, Town or L	ocation					10d. Inside City Limits
	he M	ecto		WARD			104 7in Code	ELLICOTT		Og. Citizen of V	What Cou	1 □Yes 2 No
	with the second	Dir	10e. Street and Number 5022 MONTGOMERY R	ΠΔΠ			10f. Zip Code	21043		og. Citizeri or v	VIIA COU	USA
	ours efter deeth with the Maryla ral', or Itema 23e or 28e-1 ehov Examerat mast ou notified at	Funeral Director		12. Was Deceden	t Ever in U.	S. 13.	Was Decedent of I	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-			can Indian,
9	or Ite	Fur	1 Never Married 2 Married	Armed Forces	No		If Yes, specify Cub 1 ☐ Yes 2 🌠 No		Hican, etc.)		k, White,	etc. WHITE
003	Jural',	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates	:					Specify		
5	s within 72 ho piene. r than "natur r in Medical	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of world	king	16b. Kind of Bu	ısiness/In	dustry
12	withi iene. than	ошь	Elementary/Secondary (0-12) 5	College (1-4or	5+)	REAL		-7		REAL E	ESTAT	ГЕ
٦	be filed ntal Hyg od other event, I	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle,	Maiden Sumam	10)	
<u>la</u>	2 should be filed within 72 hours efter deeth with the Maryland and Mental hygiene. ie marked other than "natural", or Itema 23e or 28e-1 show raumatic event, the Medical Exercites must be collised at	ToE	HARRY			ROCH	KIND	LENA	Ul	NOBTAINA	ABLE	
Maryland 21215-0036	2 sho	. 9	19a. Informant's Name/Relationship (Ty) LANCE STEPHEN DEU		N.			RK ROAD -				
	is 1 and 2 should of Health and Men item 27 is marks other traumatic		20a. Method of Disposition	10n / 30	20b. P	lace of Disp	osition (Name of		Date	20c. Location -		
lo			1 🛱 Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	emoval from Stat	e   c	emetery, cre	matory`or other pla _OH_CEMET		2/2004			N, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	90 , 1	DET		2. Name and Addre		L LEVINS			
ä	permit. Departn Imports any nit		Seatt M	little	^		3900 REIS	TERSTOWN				
- 1			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that cause ne cause on each	ed the death line.	n. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	End	SY	age	Renal	Disease	>		1	Unknown
	/Medical Examiner		resulting in death)	Due to (or a	1	uend of):	400 - L	Fo	1			unkaren.
6		er	Sequentially list conditions, if any, leading to immediate	Due to (or a			rient	191	IUVE		^	Strift But Strolle.
٧,	outed nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Per	iche	ral	Vascul	lar p	isease	2	1	unknown
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9 X	leath certific attending pl	by Physician/Me	IF FEMALE:	3c. If yes, outcom						23d. Dat	e of deliv	erv
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant			□Ectopic pregnanc □ Other <i>(specify)</i> _	У		Moi		Day Year
P.O.	that the de ed by the detached	hys	9 Unknown	9□ Unknown	<del></del>							
~ °,	es tha igned be de	ру Р	Part II. Other significant conditions con	ntributing to death	Λ	_	underlying cause gr	ven in Part I.				he cause of death?
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tche l	e law hes b	Completed	Hyper tensi	1					24a. Was a autops perfor	in 24b. V	Vere auto prior to co leath?	ppsy findings available empletion of cause of
+c ital F									1 ☐ Yes	2 No 1	Yes	2 No
- <del> </del>	Physician: Tribis certificer	o Be	25. Was case referred to medical examiner?	lospital: 1 Inpa	tient 2	ER/Outpatie	nt 3□ DOA Ott	hon	th (Check only or ome 5 Resid		or (Coosi	6.1
S 50	ding Phy h. After this funeral d	n: To	27. Manner of Death	28a. Date of in (Month, D		28b. Time of			28d. Describe h			97
ion	- a - a	atio	1 Natural 5 Pending 2 Accident investigation	(MOITH), E	ay rour,	mjury		Yes 2 □ No				
>15 livisi	frer de liracto n by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I building,	njury · At ho etc. <i>(Specif</i>	ome, farm, s y)	reet, factory, office		28f. Location (S City or Town		er or Run	al Route Number,
ع ا	Hospitat or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1 Certifying Physics	sician: To the bes	st of my kno	wiedge, dea	th occurred at the ti	me, date and place	and due to the c	ause(s) and ma	nner as s	stated
	To the Hospitat or Atte within 24 hours after de To the Funeral Diracto completely filled in by th	edicai	(Check only 2 Medical Exami	ner: On the basis and manner:	of examina	tion and/or i	nvestigation, in my	opinion, death occur	rred at the time, o	ate and place, a	and due t	o the cause(s)
	withir To th	M	29b. Signature and title of pertifier	1/		5	29c. Licen:			9d. Date signed		
			1/m	11			P	1870	5 /	lovem be	25	50,2004
	10		30. Name and a dress of person who co	44.0	death (Item	23a) (Type	Print)	ton A.	ONIAD	R- 14		30,2004 R MD2124
	Sta	ate	Hndiew Green 31. Date filed (Month, Day, Year)	32. Legis	strar's Signa	tue _	Cast &	, -1 1 10	erivi <del>«</del>	Den 1/1	VICO	K 1 (1) 01(0)
	Regist		DEC 0 3 20	04	we .	0 1						

State of Maryland / Department of Health and Mental Hygiene 38317 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** George W. Neisser 2004 DURNDER /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner KIVERSIDE If Under 24 Hrs 8. Date of Birth Month, Day, Year) July 29, 1927 If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign 6. Sex Funeral Days Hours Months 1 € M 2 □ F Mary Land 77 219-10-4281 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be more.

Department of Heelth and Mantal Hygiene.

Important: if Item 27 is marked other than "naturel", or items 23s or 28e-f show important: if Item 27 is marked other than "naturel", or items 23s or 28e-f show injury or other traumatic evant, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Harford Joppa Md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21085 U.S.A. 331-Al Trimble Road Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. l A Yes 2 □ No f Yes, Give 1 Never Married 2K Married white 1 ☐ Yes 2 No Specify: Maryland 21215-002( Specify. Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) self-employed 8 years carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alice (unknown) Neisser Arthur Neisser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 706 Jonathan Drive, Joppa, MD 21085 Shirley Bishop/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 12/2/04 Bayview Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner 2d stage or Attending Physician: The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1/∆Yea 2□ No 3 Probably 4 Unknown ģ cete hes been sig r, pege 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 10 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this funerel of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation efter death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours eft To the Funeral DII completely filled in Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) **1** 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) elle un 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Hugo В. Norm /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Franklin Square Rosedale Hospital Center Ba Himore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) August 1,1925 Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F Months Days Hours Min. 217-38-1227 79 Director Estonia Usuel Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5802 Plumer Avenue 21206 238 U.S.A. Funerai or Itams 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2√X No Specify: Specify: 3 ₩ Widowed 4 Divorced "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than." Elementary/Secondary (0-12) 12 College (1-4or 5+) General Superintendant Pompei Olive Oil Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oskar Norm Helene Vall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Talvi Maskell- Daughter 5909 Plumer Avenue Baltimore, Maryland 21206 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō injury Gardens of Faith Cemetery 12/6/04 Baltimore, Maryland 21. Signature of Funeral Service Licensee Heather Cain 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Acute Myo Cardial Due to (or as a consequence of): **Physician** Acute /Medical Examiner therosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and physician a the burial-1 Due to (or as a consequence of) Physician/Medical the attending p as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ peq cate has been sig page 2 should b 2 12 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' certificate Division of Vital 2 11/0 To the Hospitel or Attending Physicien: rector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Unpatient 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Stephanie 31. Date filed (Month, Day, Year) 9000 tran' 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

	an									ate of Death 3. Time of De doubt 28, 2004 20:30				
/Medic				iswender	1 41 611 7	1		NOVEHD			20:30			
Examin	er	4a. Facility Name (If not institution, 7440 Edgewood F	Road		Ai	own, or Location	is		An	Anne Arundel				
uneral irector		5. Social Security Number  160-56-0750  Usual Residence of Decedent	6. Sex 7. Ag 1 M 2 □ F	ge (In yrs. last birthda 36 Yrs.	y) If Under 1 Months I	Days Hour	ler 24 Hrs. s Min.	8. Date of Bir (Month, Da Aug. 18	v Year)	9. Birth Con Pen	nplace (State or Fore untry) nsylvania			
tural, or items 23e or 28e-f show al Examiner must be notified at		10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Lin			
	ctor	MD Anne	Arunde1	Annapo	lis						1 □ Yes XX			
	Funeral Director	10e. Street and Number 10f. Zip Code 7440 Edgewood Road 2140.							10g. Citiz	. Citizen of What Country?				
ns 23.	era	11. Maritaf Status	12. Was Decedent	t Ever in U.S. 13			Origin? (Spe	cify Yes or No	)- 1	USA 4. Race - Amer	rican Indian,			
al', or Items izaminar n	þ	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	Armed Forces	No	If Yes, specify  1 ☐ Yes 2X	_	c Origin? (Specify Yes or No- xican, Puerto Rican, etc.) ecify:			Black, White, etc.  Specify: White				
natr	Completed	15. Decedent' (Specify only highes:	t grade completed)	(Giv	cedent's Usual ( ve kind of work of DO NOT use	Occupation done during m retired)	ost of working	ng	16b. Kin	d of Business/I	Industry			
other then	mo	Elementary/Secondary (0-12)	Colfege (1-4or	5+)	Periop				Phar	rmaceut	icals			
vent,	Be C	17. Father's Name (First, Middle, L	_ast)			18. Mc	ther's Name	(First, Middle,						
marked o	Tof	Karl W. Neiswe	nder			S	usan k	Ceister						
7 is my treum		19a. Informant's Name/Relationsh			iling Address (S						ip Code)			
Item 27 i	1	Karl W. Neiswer	nder (Fathe	20b. Place of Dis				ate PA		L ation - City or I	Town, State			
y or c		1 ☐ Burial 2XXCremation 1 ☐ Donation 5 ☐ Other (Sp		Metro C			12/4/	2004		imore,				
Importent: If Ite any injury or of once.		21. Signature of Funeral Pervice L			22. Name and A Hardes	J	1			LIHOLE, I	Ш			
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ysician Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final	only one cause on each	fine					Hest.					
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ledical aminer parial-transit	icai Examiner	disease or condition	b. Chronic Due to (or as	nsive Card	iovascu			Toppidoly a			Interval Between Onset and Death			
ledical am and prize as the prize and prize as the prize transit	Icai	disease or condition resulting in death)  Sequentially list conditions, if any, leading to inmodiate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as b. Chronic Due to (or as c. Due to (or as d. 23c. If yes, outcome	nsive Card s a consequence of): Alcoholis s a consequence of): s a consequence of): e of pregnancy 2 □ Fetal death	iovascu	lar Di		Toppidoly a		3d. Date of delik Month	Onset and Death			
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			For State Registrar	State of Ma	aryland	l / Depa <i>Cer</i>	irtment of H <i>tificate of I</i>	lealth an D <i>eath</i>	d Mental Hy	giene Reg. No		38320		
		1.4	Decedent's Name (First, Middle, La.	st)				-	2. Date of Do	aath		3. Time of Death		
	Physici /Medio		Amy Elizabeth Phi	llips					Month Novemb	Da Derr 2	y Year 26, 2004	7:00 P <sup>M</sup>		
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of D			. County of Death			
			Johns Hopkins Bayv				Baltim				N/A			
E	Funeral Director		217-00-8820	ex 7. Age	e (In yrs. Ias 2	st birthday) 0 Yrs.	If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date of Bi (Month, D Aug 1,	rth a <i>y, Year)</i> 198	9. Birth	nplace (State or Foreign unity) y Land		
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits		
	Manyl f sho	ō	MD			imore						1 Pres 2 No		
	the rossa	rec	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	untry?		
	h with	Funeral Director	909 Barre Street				21230			Uni	ted Stat	es		
	deat	ner	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	. 13. V	Vas Decedent of H	ispanic Origin	? (Specify Yes or No uerto Rican, etc.)	0-	14. Race - Amer			
980	d within 72 hours after death with the Maryland jiene. rr than "natural", or Itams 23a or 28a-1 show the Medical Evand or must be Lodified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 7 N If Yes, Give Year or Dates:	No		Yes 25 No	Specify:	derto moan, etc.)		Black, White Specify: Whit			
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21215-0036	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L Cashi	kind of work done o DO NOT use retired Ex	)	WORKING	Serv	vice Sta	tion		
<u>5</u>	라 수 를 는	Be Co	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	, Maiden	Surname)			
lan	should be fand Mental B markad oi	To B	James Harold Phil	lips				April	W. Batts					
Maryland	d 2 should th and Men 7 is marks traumatic		19a. Informant's Name/Relationship (	**					r Rural Route Numb			ip Code)		
imore,	≥ = ~ =		James Harold Phil	lips				Castl	ewood, VA		24224			
	Pages 1 nent of Ho int: If itan		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		cen	netery, cren	sition (Name of natory or other place		Date Dec 3 2004		cation - City or 1 sville,			
	artin orta inju		° 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service) inject		10038		ce Cremat		neral Alt			110		
ä	Depa Impo any ir		> Stephen Loke	mann		8	717 Gree	n Pastu	res Drive	e Ba	altimore	, MD		
В			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each lin	the death.		,	100	7	rrest,		Approximate Interval Between Onset and Death		
	Pnysician /Medical	i H	Immediate Cause (Final disease or condition resulting in death)		lmona.		hromboen	nholism	η			Onsor and Dozar		
	Examiner		f	Due to (or as a	a conseque	now of):								
	表	ler	Sequentially list conditions,	b. Oue to (crest	з сопведии	mou of:					-			
	cuted Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.										
, 0	e exerian ar urial-t	i Ex	resulting in death) Last	Due to (or as a	a conseque	nce of):								
68760,	lificate be executed g physician and as the burial-transit	edicai		. d										
	± on e	/Me	IF FEMALE:	23c. If yes, outcome	of precessor	·v								
Вох	eath certi attending I for use a	cian	23b. Was decedent pregnant in the past 12 months?	Live birth	2 Fetal d	eath 3 th 5	Ectopic pregnancy Other (specify)				23d. Date of delive Month	very Day Year		
0	at the de by the	Physician/M	1  Yes 2  No 9  Unknown -	9□ Unknown		0	Cirioi (apociiy)			N	ovember	26, 2004		
S, P	igned b	by Pi	Part II. Other significant conditions of	ontributing to death bu	ut not resulti	ing in the un	derlying cause give	on in Part I.	23e. Did 1		14	the cause of death?		
ord	w require been sig should b								_ 10	Yes 2	<b>I</b> No 3∏Pro	bably 4 □Unknown		
Vital Records,	has has	Completed							24a. Was		24b. Were aut prior to co death?	opsy findings available ompletion of cause of		
<u></u>		e Co	25. Was case referred to medical		-				1 🔏 Yes	2 🗆 No		2 ☐ No		
5	Physician: this certific ral director,	0	examiner?	Hospital: 1 KInpatie	ot 2 🗆 EF	P/Outpatient	3□ DOA Othe	_	Death <i>(Check only o</i> g H <i>o</i> me 5 ☐ Resi		6 FlOther (See	6.1		
JO L	g Ph) er thi	ı.	27. Manner of Death	28a. Date of Injur (Month, Day		8b. Time of	28c. Injury	at	28d. Describe			14)		
joi	Attanding r death. ector: After by the fune	atio	1 Matural 5 Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No											
Division		Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At hom c. (Specify)	e, farm, stre	et, factory, office		28f. Location ( City or To	Street an wn, State	d Number or Rur )	al Route Number,		
	Hospit 4 hour Funera ely fille	edical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exan	ysician: To the best on the sais of and manner sta	examination	edge, death n and/or inv	occurred at the timestigation, in my op	e, date and plainion, death o	ace, and due to the courred at the time,	cause(s) date and	and manner as s place, and due t	stated. to the cause(s)		
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier				29c. License	number		29d. Dat	e signed (Month,	Day, Year)		
			Vamet & MA	thall and			0.C	.M.E.		Nove	ember 27	, 2004		
	X		30. Name and address of person who	completed cause of de	eath (Item 2			et. Bal	ltimore, 1					
	Sta		31. Date filed (Month, Pay, Year)	32. Registra			-			····y		<u> </u>		
	Registr	ar	mr 109 5	2004	pero	13	Spark	2						

State of Maryland / Department of Health and Mental Hygiene 38321 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2004 11:35 PARKER HERBERT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 213.28.9665 Director MO Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23e or 28e-f show other traumetic event, Ite Medical Examinar must be notified at BALTIMORE GNYNN MD 1 ☐ Yes 2 ☑No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 4209 Wentworth U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: 3 ₩idowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BALTO, COUNTY permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumetic event, Ille Ma College (1-4or 5+) Elementary/Secondary (0-12) Custodian PUBLIC SCHOOLS Leth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routé Number, City or Town, State, Zip Code) 1541 Lanaford Baltimore, MD Charmaine Parker Dangmer 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 12.091.04 WOODL WOODLAWN 4 Donation 5 Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility
Valigh D. Greene Funery services 23a. Part1. Enlayle disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTIMORE MD Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician SHOCK HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 2 DAYS BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Box 68760. be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown RENAL DISEASE STAGIE Be Completed this certificate has been RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🗓 No 1 TYAS 2 🗆 No funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 5801 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 GREENE EMILY BALTIMORE, MD 21201 BELLAVANCE 31. Date filed (MOTE Cay Year) 2004 32. Ragistrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 29, Joseph L. Perry 2004 6:30 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Saint Martin's Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Sept. 7, 1916 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** 1以 M 2□ F Months Yrs. 88 088-24-0759 Director Usuel Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Depentment of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Fallston Directo Maryland Harford 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2510 Aintree Lane u.s.A. 21047 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2X Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementery/Secondary (0-12) Guidance Counselor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Margaret McElrou Jack Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph M. Perry (son) 1509 Pinnacle Rd., Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremetion 3 ☐ Removal from State John's Ch. Cemetery |12/3/04 Hydes, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Road, Baltimore, MD 21236 23a. Part1. Enjoy the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner WIDN signed by the ettending physicien end d be deteched for use as the buriel-transit The law requires thet the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that inifieted events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 \$\tilde{A} No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28e. Date of injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

State Registrar 29b. Signature and title of certifier

AMBANDAM

31. Date filed (Month, Day, Year)
DEC 0 3 -2004

na

82. Registrar's Signature

30. Neme and address of person who completed cause of geath (Item 23a) (Type, Print)

SASKAL

29d. Date signed (Month, Day, Year)

WILKENS NE, BALTIMORE, MD 21229

			1 - For State Registrar		aryland / [				Mental Hy	giene Regino	04 3	3832	23		
	Physici	an	Decedent's Name (First, Middle, Last	st)							Voor	3. Time of	Death		
	Physici /Medi		Rita Fi	icchi	P	rice	### Annapolis ##								
	Examir	ner	4a. Facility Name (If not institution, give	e street and number)	Price  Price    County of Death   Price   Pric										
	-,		Ginger Cove	Second Date   Second Date											
1	Funeral		1						(Month, Day	v, Year)	Coun	try)	_		
	Director		194-18-6014 Usual Residence of Decedent		88	TIS.			Jan. 21	,1916	Penns	sylvani	La		
	show		10a. State 10b. County		10c. City, Tow	n or Loca	tion				11	0d. Inside Cit	y Limits		
	Mary -f sh	to	MD Anne Art	ınde1	Annan	olie						1 🗆 Yes	2 <b>XX</b> No		
	1 the	rec	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·	Miliapo	0115	10f. Zip Code			10a. Citizen	of What Coun	trv?			
	3a o	D	9206 River Creso	ent Drive			2	1401							
	deat	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Wa	s Decedent of Hi	ispanic Origin? (St	pecify Yes or No-	14. [	Race - Americ				
9	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show diest Examiraer must be natified at	F	1 Never Married 2 Married		No	1			o Hican, etc.)						
93	ours	D D	3 XWidowed 4 ☐ Divorced	Year or Dates:	1942-46	6 1	Tes 2LA No	Specify:		Spe	ecity: W	hite			
21215-0036	72 h 'natu	Completed by	15. Decedent's Ed (Specify only highest gra		16a.	. Deceder (Give kin	nt's Usual Occupa	ation during most of wor	kina	16b. Kind o	f Business/Ind	lustry			
121	within ene. then "	μ	Elementary/Secondary (0-12)					)							
	iled v tygie thar t		17. Father's Name (First, Middle, Last)		Te	eache	r	40. 14. 15 1. 11.	- /=:						
Maryland	2 should be filed within and Mental Hygiene. is marked othar then "reumetic event, Ire Mar	Be	Frank Ficchi								пате)				
Ž	d Me nark netic	2	19a. Informant's Name/Relationship (7	Firma Orintl	105	A d a little in it	Add (2)								
Ma	d 2 s th an 7 is r treur														
es	jes 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mantal Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28a-f show if item 27 is marked other then "naturel", or Items 23a or 28a-f show or other treumetic event, If a Madical Examinat must be nutified at		20a. Method of Disposition	on (baugn)	20b. Place of	f Dispositi	on (Name of	1							
Baltimore,	Pages nent of I nnt: If its		1 Burial 2 X Cremation 3	Removal from State	cemeter	ry, cremat	ory or other place	1							
Ħ	artme orten injury		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Solvinge Licen</li> </ul>		Metro						nore, M	D			
Ba	permit. Pages. Department of H Importent: If ite any injury or ot	Hardesty Funeral Home P.									polis, MD 21401				
н			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lir	I the death. Dor ne.	not enter t	the mode of dying	, such as cardiac	est,	Interval Between					
	Physician	Immediate Cause (Final disease or condition ) ( OROWAN ANTENI DISEASE									F	Onset and De	∍ath		
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	ped Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (a) as a consequence of):											
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68760,	icate be executed physician and s the burial-transit	alE			·	•									
687		edical		0											
Xo	law requires that the death certifi as been signed by the attending 2 should be detached for use as		IF FEMALE: 23b. Was decedent pregnant							234	Date of deliver				
m	death a atte d for	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No							1	· · · · · · · · · · · · · · · · · ·	,	ar		
0	at the de by the tached	hys	9 Unknown	9□ Unknown											
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Ä	0 - 0	Completed		perform	autopsy prior to completion of compensation of										
ita	i <b>ician:</b> Th certificate ector, pag	a	25. Was case referred to medical												
>	\$ 5 E	o B	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Out	tpatient	3□ DOA Othe				ther (Specify)				
	ding Ph h. After th funeral	T:U	27. Manner of Death	28a. Date of Injur	y 28b. T	Time of	28c. Injury	at					Peath  a M  Foreign  a  Limits  CANNO  Been ath		
0	eat be	atlc	2 Accident investigation		, , , , , , , , , , , , , , , , , , , ,										
Division	after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of Inju	ury - At home, far	rm, street,	factory, office		28f. Location (St. City or Town	reet and Nui	mber or Rural	Route Numbe	er,		
	itel c irs af rel D lled it	Ce		š						,					
	To the Hospitel or Att. within 24 hours after de To the Funerel Direct. completely filled in by the	edical	29a. Certifier  (Check only one)  Certifying Phy  2 Medical Exam	ysician: To the best of iner: On the basis of and manner sta	examination and	, death oc d/or invest	curred at the time, date and place, and due to the cause(s) and manner as stated igation, in my opinion, death occurred at the time, date and place, and due to the					ted. he cause(s)			
	To t withi To tl	ž	29b. Signature and title of certifier				29c License	number	25	9d. Date sign	ned (Month, D.	ay, Year)			
	4		1 Nula	alus			100	(4768		12/	2/04				
	20		30. Name and address of person who e	empleted cause of de	eath (Item 23a) (	Туре, Ргіг	nt) /	- 1	7 .	0					
	U		William H. A	apples )	ζ.		SAM	enagol	es r	nd.	214	01			
	Sta Registr	- 4	31. Date filed (Month, Day, Year) DEC 0 3 20	32 Registra	r's Signature	for	de la	V							

			1 - For State Registrar	State of M	arylan	-	artment rtificate			and M	Re	g. N20	04	38324		
П	Physici	an	Decedent's Name (First, Middle, Last)     Ruth		Pr	eslops	kv				2. Date of Deat Month Novembe	Day	Year	3. Time of Death		
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		свіора		Town, or	Location o	f Death	мочешье	4c. Count	2004 y of Death	11:15 a <sup>™</sup>		
1		~ (2)	1313 Donald Aven	ue				Seve	rn			An	ne Ar	undel		
	Funeral Director		5. Social Security Number 6. Sex 216-18-5630	7. Ag	e (In yrs. 86	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, May 21,	<sup>Year)</sup> 1918		place (State or Foreign htty) 1and		
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits		
	e Mar	ctor	MD Anne Aru	ndel	S	evern								1 ☐ Yes XXNo		
	vith th	Director	10e. Street and Number				10f. Zip				10	g. Citizen of		ntry?		
	eath v	Funeral	1313 Donald Avent	1e 12. Was Decedent	Ever in U	.S.   13.1	Was Deced	211		nin? (Spe	ecify Yes or No-	USA 14. Ba	ce - Americ	can Indian		
980	within 72 hours after death with the Maryland liene. r than "natural", or items 23s or 28s-1 show the Medical Exar, it we must be rediffed at	by Fun	1 ☐ Never Married 2 ☐ Married  3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	)		f Yes, spec		Specify:	, Puerto	ecify Yes or No- Rican, etc.)	Bla	ck, White,  fy: Whi	etc.		
Maryland 21215-0036	72 ho	Completed	15. Decedent's Educ			16a. Deced	kind of wor.	k done d	lurina most	of worki	na	6b. Kind of E	Business/In	dustry		
121	within ene.	mple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT us Tech	e retired)	)			Uo a t d				
d 2	the it		12 17. Father's Name (First, Middle, Last)	···		Бар	recii		18. Mothe	r's Name	(First, Middle, A	Westi		ise		
/an		To Be	Joseph Duke Clark						Sara	ah Is	sabelle	Clark				
lary	s 1 and 2 should be f Health and Mental I Item 27 is marked of other traumatic eve		19a. Informant's Name/Relationship (Type	рө, Print)							l Route Number,	•		Code)		
	and lealth m 27 her t		David Cox (Son)  20a. Method of Disposition		20h F	1280 Place of Dispo			Aver		Severn,	MD 21		Shaka		
nor	ages nt of h t: If ite		X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	0	emetery, crer	natory or ot	ther place	.							
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		' 4 □ Donation 5 □ Other (Specify)  21. Signature of Fun stal Service Licenter	1	GTE	n Have					/2004 Home, P.	Glen B	urnie	, MD		
ä	Depa Impo any ir		Vall (1	7		Į.					, Annapo		4D 214	401		
	/Medical Examiner	Examiner	23a. Part1. Enter/the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Ac F	hrif	g, such as	cardiac o	r respiratory arre	st,	1	Approximate Interval Between Onset and Death Oy Can S					
O. Box 68760,	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 2 2 4 No 9 \( \text{Unknown} \)	Due to (or as	of pregna	ancy	Ectopic pre						ite of delive	ory Day Year		
ds, P.	es tha	by	Part II. Other significant conditions con	tributing to death b	out not res	ulting in the ur	nderlying ca	iuse give	n in Part I.			acco use con		ne cause of death?		
Vital Record	The law ate has b page 2 sl	Completed									24a. Was ar autopsy perform 1 \sum Yes 2	ed?	prior to cor death?	psy findings available impletion of cause of 2 No		
Vita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)												
Of Phys ratidi	ding Phys h. After this funeral dii	ation; To	1 Yes 2 Ao  27. Manner eath  1 tural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?						2	Home 5 (Presidence 6 □Other (Specify)  28d. Describe how injury occurred					
Division	Diffe of	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Str City or Town	Bf. Location (Street and Number or Rural Route Number, City or Town, State)				
	the Hos in 24 h the Fur ipletely	edicai	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	ician: To the best ner: On the basis of and manner st	f examina	wledge, death tion and/or inv	estigation,	in my op	inion, deat	d place, a h occurre	ed at the time, da	te and place,	and due to	the cause(s)		
	2 1 1 2 0	M	29b. Signature and title of certifier	Mut	m	)	29c.	P 2	-00 9	4	29	d. Date signe	9 (Month, 1) 9/04	Day, Year)		
	X		30. Name and address of prison who co Elliot Torbe 31. Date filed (Month, Day, Year)	chus,	leath (Item	Cycle (Type	Print)	Pan	KI	rev	e Gla	Bri	100	4d, 2106/		
	Sta Registr	2 2 2	DEC 0 3 2004	See Les	K Signa	Loon	2									

1		1- For Unpend Item 2		/ Department of Heal r me G840 2-1-05 Certificate of Dea		
Phys	ician dical	1. Decedent's Name (First, Middle, Las Dianne		Patrick	2. Date of	
1	niner	4a. Facility Name (If not institution, give 5617 SPECTRUM DR		4b. City, Town, or Loca FREDERIC	tion of Death	4c. County of Death FREDERICK CO
Funera Directo		5. Social Security Number 6. Sec. 212-74-8338	x 7. Age (In yrs. last ☐ M 2 ■ F 41		urs Min. 8. Date of (Month,	Birth Day, Year)  9. Birthplace (State or Foreig Country)  16,1963  California
ne Maryland 8a-f show	ector	10a. State 10b. County  Maryland Frederi		own or Location derick		10d. Inside City Limit 1
faryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other then "natural", or Items 23a or 28a-f show eumatic event, the Medical Examiner invat by modified at	by Funeral Director	10e. Street and Number  1074 Redfield Cour  11. Marital Status	t Apt 1-A	10f. Zip Code  21703	o Origin? (Specify Ves et l	10g. Citizen of What Country?  U.S.A.  No- 14. Race - American Indian.
0036 nours after ourselt, or Iter	d by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		ecity:	Black, White, etc.  Specify: White
21215-0036 od within 72 hours afgione. The matural, or the Medical Exercise.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e completed)  College (1-4or 5+)  N/A	6a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Student	most of working	16b. Kind of Business/Industry
be filed tal Hyg of other	Be	17. Father's Name (First, Middle, Last)	1	18. N	Mother's Name (First, Midd	College He, Maiden Sumame)
Maryland od 2 should be file tith and Mental Hy 27 is marked oth	은	George Ba		The second secon	nrol umber or Rural Route Num	Jane Berry nber, City or Town, State, Zip Code)
<b>≥</b> 5 € 5 €		Carol J. Berry (Mo	other)			rederick MD 21703  20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item:	once.	`4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		iew Crematory  22. Name and Address of F McCully-Polyn 130 E. Fort A	11/16/04 Liak Funeral	Baltimore, Maryland
Attending Physicien: The law requires that the death certificate be executed reach.  Attending Physicien: The law requires that the death certificate be executed reach.  The law requires that the death certificate be executed by the attending physician and be proposed by the tuneral director, page 2 should be detached for use as the burial-transit	ical Examiner	23a. Part Lenter the disease, or comp shock, or heart failure. List only of limited the cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	no not enter the mode of dying, such that a complicated set of:	h as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death
cords, P.O. Box 68 v requires that the death certifies been signed by the attending phe should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9N⊇Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown			23d. Date of delivery Month Day Year
cords, P w requires that been signed b	by	Part II. Other significant conditions col	atributing to death but not resulting	g in the underlying cause given in P		tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknow
on of Vital Rec ding Physicien: The law h. After this certificate has b tuneral director, page 2 st	e Completed	25. Was case referred to medical		00.8	Per Yes	opsy prior to completion of cause of death? 2 □ No 1 □ Yes 2 □ No
of Vi Physici this cer	To B	examiner? 1√√es 2 No	ospital: 1 Inpatient 2 ER/	Outpatient 3 DOA Other: 4	lace of Death (Check only  Nursing Home 5 Res	sidence 6 X ther (Specify) SCENE
in Paris	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	foundh, Day Year) fo	08 P M 1 □ Yes 2	Head ar front s	nd neck down between 2 seats of her car (Street and Number of Bural Route Number of Wind, State) 5017 Spectrum Dr
Hospitel	edicai	29a. Certifier (Check only one)  1☐ Certifying Physical Exemination	sicien: To the best of my knowled ner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and/or investigation, in my opinion,	and place, and due to the	
To the within 2 To the comple	Me	29b. Signature and title of certifier	helfule W	29c. License numb O C M		29d. Date signed (Month, Day, Year) NOVEMBER 14, 2004
		30. Name and address if person who company to the person who company t	KORELL	111 Penn	Street, Balt	imore, Maryland 21201
S Regis	tate strar	31. Date filed (Month, Day, Year)	32 registrar's Signature	Sporte		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ 0 0 L Certificate of Death 2 Date of Death I. Decedent's Name (First, Middle, Last) Year Month **Physician** 2:28 P M November Ouick 28, 2004 Richard Dean /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dundalk Baltimore Co. 1853 Portship Road 8. Date of Birth (Month, Day, Year) April 18,1939 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Months 1 1 ℃M 2 □ F Director 65 Maryland 220-36-4563 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Dundalk <u>Maryl</u>and Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 United States 1853 Portship Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Types 2 No
If Yes, Give
Year or Dates: 1961-64 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 TXNo Specify Specify 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) 2 Years Steel Worker Steel Industry permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Importent; if item 27 ie marked other any injury or other treumatic event, I. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Elizabeth Martini Earl Dean Ouick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1853 Portship Road Dundalk, Maryland Mrs. Sherma L. Quick / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 12/2/2004 Middle River, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 2—2441 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed to home store death attending physician and for use as the burial-translt that initiated events resulting in death) Last Due to (or as a consequence of): by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 1 ☐ Yes 2/2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 🗌 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Siani, MD. 6730 Holabird, Aye Dundalk, MD 21222 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:10 AM 30 2004 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Baltimore Bultimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) 1 1 M 2 □ F 229-07-935 Usual Residence of Decedent Yrs. VOU. 02, 1920 VIRGINIA 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Tes 2 No 10e. Street and Number 10g. Citizen of What Country? 5029 454 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WELDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a.
Importent: If item 27 is 1.
any injury or other 1.
Once. 5029 BALTIMERE, MO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) CIVERTY HOHITS se, or complications that caused the dwith. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancientic month Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 0 No 2□ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

P.0. of Vital

Hospitel or Attending Physicien: The law requires that the death certificate be executed

Funeral

Director

show

item 27 is marked other then "naturel", or Items 23a or 28e-f st other treumatic event, the Medical Examinar must be notified

2 should be filed within and Mental Hygiene.

Physician

Examiner

/Medical

as the burial-transit

atient Known as Rice, Robert

State Registrar

DHMH 17 Rev 1/2001

filled in by the funeral director,

Medical

within 24 hours after death To the Funerel Director:

the

2

1 Natural

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending

investigation 6 Could not be determined

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

RES OUO

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD, Sinai Hospital of Baltimone, 2401 W. Belvedea Ave, Bettinoa, MD Hany Bashandy 31. Date filed (Month, Day, Year)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DEC 0 3 2004



Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 38328 - State Registra Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Anne R. Reese 8:00AM 2004 Dec /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Timonium Baltimore 200 Belmont Forest Court #108 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M X F Yrs. 79 Director 16, 1924 Maryland 216-24-4965 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Directo Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21093 USA 200 Belmont Forest Court #108 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Davis Allen 2 Charles H. Roloson Jr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
200 Belmont Forest Court #108
Timonium, Maryland 21093 19a. Informant's Name/Relationship (Type, Print) George R. Reese, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 12/03/04 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society Of Maryland Inc 299 Frederick Road Baltimore, Mary Thomas Gregor Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician SYSTEMIC AMYLOIDOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Vear in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2□ No 1 Yes 2 No 1 TYes or Attending Physicien: ours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funeral L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 57357 TIP. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amit Khosla M.D. 8415 Bellona Lane Ste. 216 Towson, MD 21204 32. Registrar's Signature Sporks State Registrar

		1	For State Registrar	State of Ma	ryland / D	epartm Certific	nent of H cate of L	ealth and N Death		giene (	104	38329
	2		1. Decedent's Name (First, Middle, L	ist)					2. Date of Dea Month	Dav	Year	3. Time of Death
	Physicia /Medic		JAMES WII	LIAM RHI	NEHART				DECEMBI	ER O1	2004	11:45 AM
	Examin	er	ta. Facility Name (If not institution, gr 1145 MC HENRY I				City, Town, or .EN BUR	Location of Death	1		unty of Death	DEL CO.
		٠			(In yrs. last birth	nday) If U	Inder 1 Year	If Under 24 Hrs.	8. Date of Birt			lace (State or Foreign
Н	Funeral Director		212-42-9456	1 MM 2□F	_60Y	rs. Mor	nths Days	Hours Min.	May 3.	7, Year) 1944		vland
	D.		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town	or Location					1	0d. Inside City Limits
	shov	5		Arundel		len B						1 ☐ Yes 2 🗷 No
	the N	Director	10e. Street and Number	AT direct			f. Zip Code			10g. Citizen	of What Coun	itry?
	3a or	0	1145 McHenry Dr	ive			2	21061			U.S.A.	
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was E	Decedent of Hi	ispanic Origin? (Si in, Mexican, Puert	pecify Yes or No	14.	Race - Americ Black, White,	
336	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "neturel; or items 23a or 28e-f show imaric event, if a Modical Examine r ust be notified at	by Fu	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:	0		es 2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	1	ecify:Whit	
5-0036	72 hor	Completed	15. Decedent's (Specify only highest g			(Give kind )	Usual Occupa	durina most of wor	king	16b. Kind	of Business/Inc	dustry
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5-		life. DO N	OT use retired	)			3.000.4	
2	filed w Hygier other ti		17. Father's Name (First, Middle, Las	0		Pr	inter	18. Mother's Nam	ne (First, Middle,	Maiden Sui	MTA mame)	
anc	d la la	o Be	George Alfred					E11		nnelly	·	
aryland 2121	2 should land Men ls marke eumatic	2	19a. Informant's Name/Relationship		19b.	Mailing Ad	dress (Street	and Number or Ru				Code)
≥	1 and 2 Health a tem 27 Is		Lana R. Rhineha	rt (Wife)		1145 I	McHenry	y Drive,		rnie,	Mary1a	nd 21061
altimore,	5		20a. Method of Disposition 1 ♥Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		20b. Place of cometen	r, cremator	y or other place		Date 03-04		ion - City or To Burnie,	own, State Maryland
Baltii	permit. Page Department of Important: If any injury or once.		21. Signature of Fundal Service Lic		11)		neral H	ome P.	.A. Marv	land 21225		
п			23a. Part1. Enter the disease, or co	mplications that caused	the death. Do n						, 1141 )	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	y one cause on each in	ostal	> <		- Alene	BALC	12/2/0	10201	Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of	of):		0		CY 10	V-04	1.103
	Examiner		Sequentially list conditions,	b		0						
	bed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a	consequence o	ot):						
	xecut and al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequ <i>e</i> nce o	of):						
8760,	icate be executed physician and s the burial-transit	dicai E		d.								
ဖ		ledic										
.O. Box	The law requires that the death certifinate has been signed by the attending I agge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 1 2 4 □ Pregnant at 1 9 □ Unknown	2 Fetal death		pic pregnancy er (specify)	,		23d	. Date of delive Month	ery Day Year
Δ.	uires that signed b id be deta	by	Part II. Other significant conditions	contributing to death bu	it not resulting in	the underl	ying cause giv	en in Part I.	23e. Did t	_		he cause of death? pably 4 Unknown
Vital Records,	e law requir has been si ge 2 should I	Completed							24a. Was autor perfo	rmed?	prior to co death?	ppsy findings available impletion of cause of
a			25. Was case referred to medical					OC Disea of Doc	1 ☐ Yes	2 No	1 🗆 Yes	21 No
	Physician: this certific ral director,	o Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ER/Out	tpatient 3	□ DOA Oth		1.7		Other (Specif	iy)
o	g Physer this eral di	-	27. Manner of Deal	28a. Date of Injur (Month, Day	y 28b. T	ime of	28c. Injur Wor		28d. Describe			,
ion	Attending or death.	atio	Natural 5 Pending investigat	ion	1001)	, july		Yes 2 □ No				
Division	al or Atter after de Directo	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		iry - At home, fai c. (Specify)	rm, streøt, f	actory, office		28f. Location (- City or Tor		lumber or Rura	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examination and	, death occ d/or investig	urred at the tir gation, in my o	ne, date and place pinion, death occu	a, and due to the urred at the time,	cause(s) an date and pla	d manner as s ace, and due to	tated. the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier.	2	10	7	29c. Licens	Se number	-/	29d. Date s	igned (Month,	Day, Year) 2,1004
	10		30 Name and address of person with	completed cause of de	eath (Item 23a) (	Type, Print	) Port	of Aruse	( Clen!	Minhe	Mi	U661
	St	ate	3. Date filed (Month, Day, Year)		ar's Signature		1. A.	- ( 0 ,		9 41 46	1	
	Regist		DEC 0 3 2004	12en vie	13	So	alst					

			For State	State of Maryla		ent of Health and	d Mental Hy	giene 004	38330
			1. Decedent's Name (First, Middle, Last		838 1270376	HIOJHI BOULII	2. Date of De		3. Time of Death
	Physic /Medi Exami	ical	4e. Fecility Name (If not institution, give	Schio street and number)		M F. SENTOR Dity, Town, or Location of De	Month	Day Year 22 6 4c. County of Dec	( C A A
			1V4 A1	7LL		Baltimore		Balt	imore_
	Funeral		5. Social Security Number 6. Se	BM 2□E	Mon	nder 1 Year   If Under 24 H ths Days Hours M	Irs. 8. Date of Birlin. (Month, Da		rthplece (State or Foreig
	Director		273-18-6427  Usuel Residence of Decedent  10a. State 10b. County	87	7 Yrs.  City, Town or Location		Mar.	2, 1917	
	ter death with the Maryland Items 23s or 28s-f show Institutifie notified at	Funeral Director	Maryland Baltimor		Baltimore				10d. Inside City Limit 1 ☐ Yes 2反
	s or 2	급	10e. Street and Number		10f.	Zip Code		10g. Citizen of What C	ountry?
	death with the ms 23s or 28a	erai	1300 Windlass Dr	12. Was Decedent Ever in	IIS 13 Was D	21220	(Specify Vec or No	USA - 14. Race - Am	accan ladian
920	क ठेड	þ	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	If Yes,	acedent of Hispanic Origin? specify Cuban, Mexican, Pu s 2□Mo <i>Specify:</i>	erto Rican, etc.)	Black, Whi	
215-0036	72 nat	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Decedent's l (Give kind of life. DO NO	Isual Occupation work done during most of v Tuse retired)	working	16b. Kind of Business	
2	e filed within al Hygiene. other than '	mo.	12	College (1-4or 5+)	Balistic	s Tester		Aircraft M	Manufacture
	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)				lame (First, Middle,		<u> </u>
<u>\{ \} \</u>	2 should be and Menta is marked aumatic so	2		Senior		Cora		erick	
, Maryland	and 2 sho alth and 27 is m		19a. Informant's Name/Relationship (Ty James W. Senior /			ess (Street and Number or Optank Drive			
ore	ges 1 and t of Health if Item 27 or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ B	20b	. Place of Disposition (	Name of	Date	20c. Location - City or	
Ĕ	Pag ment ant: i		'4 □Donation 5 □ Other (Specify)	H		vice Corp.11-	-29-04	Towson, Ma	rvland
Baltimore,	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Licens		22. Name McCor 1317	and Address of Facility Nas Funeral F Cokesbury Ro	lome, P.A.		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complished the specific or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	cations that caused the dene cause on each line.  Due to (or as a bons)	come .	Dechne	ident	rest,	Approximate Interval Between Onset and Death
,0070	icate be executed physician and sthe burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consorting Due to (or as a consorting Due to (or as a consorting Degree Degre	rentre	Jant 1			
r.O. DOA 00	ath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3 DEctopic	c pregnancy (specify)		23d. Date of del	ivery Day Year
ר יטש	uires that the de n signed by the a id be detached f	þ	Part II. Other significant conditions con	tributing to death but not re	esulting in the underlyin	g cause given in Part I.		bacco use contribute to	
necolus,	The law requate has been page 2 should	Completed	typeth.	poolin			24a. Was a autops perform	y prior to c	itopsy findings available
VII	iician: T certificate rector, pa	CO	25. Was case referred to medical				1 ☐ Yes	2 ☐ No ☐ 1 ☐ Yes	2□ No
>	Physician: this certificatal director, p	To B	examiner?	ospital: 1   Inpatient 2[	☐ ER/Outpatient 3☐	044	eath (Check only on	ence 6 Other (Spec	
			27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?		ow injury occurred	cify)
2	Attending I death. ctor: After y the funer	atio	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	1 Yes 2 No			
DIVISION OF	sal or Atte s after de al Directo ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, factify)	ory, office	28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune fune	Medical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kr er: On the basis of examinand manner stated.	nowledge, death occurr nation and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the ca curred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within To the Comp	M	29b. Signature and titler of certifier	2	mp	29c. License number D31464	2	9d. Date signed (Month	
	01		30. Name and address of person who con SttDAII3 A. H	mpleted cause of death (Ite	em 23a) (Type, Print)	FUTAW ST	ShITE.	300 Bel	Imm mb
	Sta Registr	te ar	31. Date fled (Month Day, Year) 2004	32. Registrar's Sign	hature Spor	KN .			

			For State Registrar	State of Ma	iryland / De <i>C</i>	epartme Certifica	ent of H a <i>te of L</i>	ealth and Death	Mental Hy	giene Reg. No		38331
			1. Decedent's Name (First, Middle, Las	1)					2. Date of D	eath		3. Time of Death
	Physici /Medic		Norma Janet Ri	gotti					Novemb	er 29	y Year 9, 2004	8.4
	Examin		4a. Facility Name (If not institution, give			4b. Ci	ty, Town, or	Location of Dear	th		. County of Dea	
			Hart Heritage				Street				Harfo	
	Funeral		Social Security Number     6. Security Number	7. Age DM 2.ScF	(In yrs. last birtho	Month	der 1 Year Is Days	If Under 24 Hrs Hours Min	. (Month, D	ay, Year)		rthplace (State or Foreign Country)
	Director		376-28-2211 Usual Residence of Decedent		73 <sup>Yrs</sup>				July 2	5, 19	931 M	ichigan
	and ow		10a. State 10b. County		10c. City, Town o	r Location						10d. Inside City Limits
	Mary Mary	to	Maryland Harfo	rd	Bel Ai	~						1. Yes 2 No
	r 288	Directo	10e. Street and Number		DET AT		Zip Code			10g. Cit	tizen of What C	Country?
	23a c		127 Duncannon Rd	•			21014	1			USA	
	ge E E	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was De	cedent of Hi	spanic Origin? (S	Specify Yes or N to Rican, etc.)	0-	14. Race - Am Black, Wh	
92	be filed within 72 hours after death with the Maryland hat Hygiene. do other than "natural", or items 23s or 28s-f show event, tra Medical Examinar must be notified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ N If Yes, Give	o		2 × No	Specify:	, , , , , , , , , , , , , , , , , , , ,		Specify: W	
5-0036	hour turaf	d b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a D	andont's II	sual Occupa	tion		16h K	and of Business	
5	in 72	Completed	(Specify only highest gra	de completed)	(G	ive kind of e. DO NO1	work done d use retired	furing most of wo	rking	10D. K	and or busines:	sindustry
2	filed within Hygiene. other than " ent, it a Mex	E o	Elementary/Secondary (0-12)	College (1-4or 5		creta	rv			Pr	civate i	Education
ğ	e fflec Il Hyg othe	Be C	17. Father's Name (First, Middle, Last)			01000	-3	18. Mother's Na	me (First, Middle			
<u> a</u>		To E	Roy William John	S				Lempi	Cather:	ine F	Hill	
Maryland 2121			19a. Informant's Name/Relationship (7	ype, Print)	19b. M	ailing Addre	ess (Street a	nd Number or R	ural Route Numi	oer, City o	or Town, State,	Zip Code)
	s 1 and 2 f Health Item 27 other tra		David L. Rigotti	/ Husband	20b. Place of Di	Dunc	annon.	Rd. Be	l Air, I	aryl	land 21	014
0	Pages 1 nent of H ont: if Ite iry or ot		20a. Method of Dispusition		cemetery,	crematory o	r other place	-			ocation - City o	•
Baltimore,	t. Pa rtmen rtent:		*4 □ Donation 5 □ Other (Specify  21. Signature of Journal Service Licen	·	Bel Air	_			04/2004	вет	Air, M	aryland
Ba	permit. Pages Department of I Importent: If It any injury or o		21. Signature dynameral service Electric	Herele		McCor 1317	and Addres	nera 1 1	Home, P.	A.	Marsi	land 21009
	1	D.	23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused	the death. Do not	enter the m	ode of dying	, such as cardia	c or respiratory	arrést,	La Mary	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	G & i			) e	and the same of th				Onset and Death
-	/Medical		resulting in death)	Due to (or as a	consequence of):	-	- un					
	Examiner		Sequentially list conditions,	b			<u>.</u>					
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
	ficate be executed physicien and is the burial-transit	хап	that initiated events resulting in death) Last	C. Due to (or as a	a consequence of):				-			
58760,	sicier burii		l	d								
89	g physias the	edical		u.						111		
Вох	leath certifi attending I for use as	ician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 □Ectopic	pregnancy				23d. Date of de	
	0 0 0	sicia	in the past 12 months? 1 Yes 2 No	4 Pregnant at		5 Other					Month	Day Year
0.	at the de	Physi	9 Unknown						40 014			
Ś	The law requires that the te has been signed by thogge 2 should be detached.	by	Part II. Other significant conditions of	ontributing to death bu	it not resulting in th	e underlying	g cause give	n in Part I.			use contribute t □ No 3 □ P	robably 4 Unknown
0.0	w require been sig should b	eted		<del></del>					-		1	
Records,	raiclan: The taw s certificate has t lirector, page 2 s	Completed							24a. Was		24b. Were a prior to death?	utopsy findings available completion of cause of
			05.14						1 ☐ Yes	2 No	1 ☐ Ye	s 20 No
5	sicla certi	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	nt 2□ER/Outpa	tient 3	Othe		ath (Check only		C []Oth (O-	
O	y Phys er this eral di	ь,	27. Manner of Death	28a. Date of Injur	y 28b. Tim	e of	28c. Injury Work		dome 5 Res			ecity)
ion	nding Fath. r: After e funera	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day	<i>Year)</i> Inju	M M		? ′es 2 □ No				
Division of Vital	To the Hospitel or Attending Physicien: within 24 hours after death as a factor. To the Funeral Director: After this certified completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ry - At home, farm, . (Specify)	street, fact	ory, office		28f. Location City or To			Rural Route Number,
۵	itelor irs afte ral Dir lled in											
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Exam	sician: To the best of the basis of	examination and/o	eath occurre r investigati	ed at the tim	e, date and place inion, death occi	e, and due to the urred at the time	cause(s) date and	and manner a diplace, and du	s stated. e to the cause(s)
	thin 2 thin 2 the	Med	29b. Signature and title of certifier	and manner sta	ted.		29c. License	number		29d Dat	te signed (Mon	th Day Year)
)	F \$ 6			7		, and						
	$\sigma_i$		30. Name and address of person who	completed cause of de	eath (Item 23a) (Tu	pe. Print)	03	2277		<b>#</b> 00.	vein he	- <) soot
	1,5			SDUL			m	a Pho	. /	Br	1000	-25, 200 f
	Sta	ite	31. Date filed (Month, Day, Year)		r's Signature	G	100			-		1
	Registr	ar	000	2004	merinan	1.	Al Detter of	Carl age				

Amend item#31, per VKP-838, 127, 37, 64 T1 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2004 11:000 Varember 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
740 POPIAR Gove 4b. City, Town, or Location of Death Examiner -54 Baltmore
If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 12-22 Months 1 M 2 F Yrs Director Jan 12,1924 marylano Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Mudical Exercise or must be indifficible at Baltimore 1 Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 USA Funeral death Was Decedent Ev Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) lech. ün 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Surname) Be moore Lona Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walters-niece-in-law 5020 Cataloha Balto, MD 21214 Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify) 3 Removal from State Arbutus Mem. Park 12-6-04 21. Signature of Funeral Service Licensee Gary P. March Flot 270 Fredhilton Pass Balto, mo 21229 1m 23a. Part. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirty, or leart tailure. List only one cause on each line. Åpproximate Interval Betweer Onset and Death Immediate Cause (Final disease of condition resulting in death) **Physician** Myocciver Investion /Medical Due to (or as a consequence of): **Examiner** Coorany Atem Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a construence of): Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day detached for 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 Who 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 40 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 2☑ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled tte Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12 3 04 Mendu 17740 30. Name and diress Hierson who completed cause of death (Item 23a) (Type, Print) JOSE GREENSPON YOSEP 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 0 3 2004 Seems A frank State 12/3/04 Registrar

State of Maryland / Department of Health and Mental Hygien [ ] [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Day randa /Medical 12 2000 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kesvi Lane Baltimore 5. Social Security Number -6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 2-12-192 Birthplace (State or Foreign Country) 1 □ M 2 1 F Months Days Hours Min -36-6448 @1 Yrs Director 12-192 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show itam 27 is markad other than "natural", or itams 23a or 28a-f shov other traumatic avant, the Medical Examinar must be notified at 10d. Inside City Limits Director MD altimore Pikesville 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 death 9ne Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is markad other than "natural", or ita 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Completed by 1 Yes 2 Into Specify: Black 3 € Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 15 Health 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Allen Smith Harris Martha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dayle M.
20a. Method of Disposition Vikesville M. Smith Lanc MO RUSIS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or permit. Page Department of Important: If any injury or Egirvica Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Staunton -04 21. Signature of Fuheral Service License 8728 Libro Kel 22. Name and Add ss of Facility Revolulistance MY) Greene Service tune 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** wil disease or condition mule resulting in death) /Medical Due to (or as a consequence of): Examiner type Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examiner Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed HASCUID that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. cal Physician/Med as IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy į in the past 12 months? Month 4☐Pregnant at time of death Dav Year 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Be Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 24a. Was an autopsy performed Division of Vital 1 Tes 2 No 2 🕝 1 ☐ Yes or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one. Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina after death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To tha Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (1000470 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANFOR MAC 31. Date filed (Month, Day, Year) 32. Registrar's Signat State DEC 0 3 2004 Registrar

StanleyLSimmemon UNK 04-380 04-07525 RJ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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ient of Health and Menta	Il Hygiene	_	110	-	-	

						Certi	ficate of	Death		Reg. No.	104	00004
	Dharaisian		me (First, Middle, L						2. Date of I	Death Day	Year	3. Time of Death
_ (	Physician /Medical	Stanley	L.	Simmemon						ber 23,		12:05 A.
	Examiner		(If not institution, gi f Suitland		ber) Northb	ound	- 1	4b. City, Town Camp Sp	or Location of Dec		ty of Death	orge's
	C.maral.	5. Social Security			. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24				
н	Funeral Director	254-57-9		<b>XX</b> M 2□ F	32	Yrs.	Months Days	Hours		0ay, Year) 6, 1972	Cour	place (State or Foreign htry)
		Usual Residence							THY	0/ 13/2	_ G	1
	yland	10a. State	10b. County		10c. City, To	own or Local	tion				1	0d. Inside City Limits
	Me not	GA	Haben	sham			C	omelia				1 ☐ Yes 2☐ No
	within 72 hours efter death with the Meryland ene. than "natural", or items 23e or 28e-f show he Medical Exeminer must be notified at ompleted by Funeral Director	10e. Street and N 3673 Mu	lumber d <b>Creek</b> Roak	đ			10f. Zip Code 30	)531		10g. Citizen of	What Cour	ntry?
	Jeath Jeath	11. Marital Status		12. Was Deced		13. Wa	s Decedent of H	Hispanic Origin	? (Specity Yes or Note: Puerto Rican, etc.)	lo- 14. Ra	ace - Americ	an Indian,
0	Fur Fur	1 Never Ma	rried 2 Married	Armed Forc 1 ☐ Yes 2 If Yes, Give					uerto Rican, etc.)	Bla	ack, White,	
07	urs e	3 ☐ Widowed	<b>Divorced</b>	If Yes, Give Year or Date	es:	1 L	Yes 2X No	Specify:		Speci	ify:	white
21215-0020	ed within 72 hours ef ygiene. her then "natural", or it, the Medical Exert Completed by F		15. Decedent's E	ducation	16	Se. Deceden	t's Usual Occup	oation		16b. Kind of I	Business/Inc	dustry
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a	Mental Arked o atlc eve	Rol	cert T. Sim	memon					Janet Sua	Jones		
Maryland	2 should end Men is marke aumatic	19a. Informant's	Name/Relationship	(Type, Print)	19	9b. Mailing /	Address (Street	and Number o	or Rural Route Num	ber, City or Town	n, State, Zip	Code)
	47 th 02 th 02 th 03 th	Robert T	. Simmemon /	Father					Cornelia (			
ā,	- I E E	20a. Method of Di	isposition		20b. Place	of Dispositi	on (Name of		Date	20c. Location	- City or To	wn, State
Baltimore,	Pages nent of int: If the Iry or o		2 ☐ Cremation 3 ☐ 5 ☐ Other (Speci				ory or other place or Cemete		mber 7, 200	4 Baldwi	n, GA	
圭	permit. Pa Departmer Important: any Injury pncs.		uneral Service Lice						1		,	
Ba	permit. Pages Department of Important: If I any Injury or phce.			VICUI		Chai	les L. S	tevens F	uneral Home	, Inc.		
	- 45		ico -		1				e, Baltimor		30	
	_	23a. Part1. Enter shock, or he	the disease, or comeant failure. List only	plications that cau one ceuse on eac	sed the death. Do	o not enter t	he mode of dyir	ng, such as cai	rdiac or respiratory	arrest,	i	Approximate Interval Between
	Physician		_								i	Onset and Death
1.6	/Medical Examiner	Immediate Cause disease or condit	ion	SHOKE	INHALATI	021.	THERMA	HELDINA	NECK IN	JARY ES	i	
		resulting in death	)		Due to (or as			1100				
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	certificate be executed reding physician and use as the burial-trensit rn/Medical Examiner	Sequentially list of	onditions,	D	Due to (or as a	a consequer	nce of):	,,,,,,,,				
Ö,		Sequentially list of if any, leading to ceuse. Enter Und Cause (Disease of	derlying	•							į į	
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œ.	v requires thet the death been signed by the etter should be deteched for to letted by Physician	Part II. Other sign	ificant conditions	contributing to deat	h but not resulting	in the unde	rlying cause giv	en in Part I.	23b. Dic	tobacco use co	ontributa to	the causa of death?
P.O.	t the								1	Yes 22No	3 ☐ Prob	ably 4 Unknown
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Ë	quire an sign ruld t									s an autopsy ormed?		re autopsy findings ilable prior to
ပ္ပ	> A-0 (7) even								_   pen	oinled?	con	npletion of cause
Division of Vital Records,	The lew requires the cate hes been signed, page 2 should be d								190	Yse 20No		Yes 2□ No
ā	ficate or, pe	25. Was case refe	erred to medical					OC Blace of			1,2	(185 2LINO
5	Physician: r this certific oral director, n: To Be	examiner?		Hospital:	0 T ED/C	Outpatient :	Oth		Death (Check only ng Home 5 ☐ Res		(0	. 40 a 100 c
o	Physic this corral dire	27. Manner of Dee		28a. Date of I		. Time of				how injury occur	rred	At scene
5	After fune fune	1 □Natural	5 Pending investigation	(Month,	Day Year)	Injury	28c. Injun Worl M 154	k? Yes 2 □ No	DRIVER	OF TRA	CTOR	TRAILER NO COLLISION
<u></u>	Attending or death.  Sctor: After by the fune iffication	2 Accident 3 ☐ Suicide	6 ☐ Could not b	e 200 Place of	Injury - At home,					(Street and Numi		
2	tal or Attending P rs efter death. al Director: After t led in by the funera Certification:	4 🗆 Homicide	determined	building,	etc. (Specify)	iaiii, 3000t,	lactory, office		City or To	wn, State)		VORD, HD
_	pltal	29a. Certifier	1 Carlifying Dh	ROA		and and and						
	ne Hospi n 24 hou ne Funer pletely fil	(Check only one)	2X Medical Exar	ninar: On the basis	s of examination a	nd/or invest	igation, in my of	pinion, death o	ace, and due to the occurred at the time	date and place,	and due to	the cause(s)
	To the Hospital or Attending Physician: The lev within 24 hours efter death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29b. Signature and	d title of certifier	and manner	JULIOU.	-	29c. License	e number	-	29d. Date signe	ed (Month I	Dav. Year)
	F3F8	•	NAND					CME		Novembe		
	1		UNUSC									
	1	30. Name and add	ress of person who	completed ceuse of	of death (Item 23e)	(Type Prin	Penn St	treet.	Baltimor	e. Marvl	and 2	1201
	U'	31. Date filed (Mod								,		
	State Registrar	J. Date med (MO)	DFC 0.3		strar's Signature	19	Spor	Kal				
			En 15 to 11 of	C MARKET F A		/	7 //					

Clifton Roose Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-07704 State of Maryland / Department of Health and Mental Hygiene 00 1 crn 1 - For State Registrar 38335 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 30, 2004 Physician Kuosevalt 5:25 P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Center Clinton Prince George's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign (Country), **Funeral** Days Hours 10€M 2□F Yrs. 223-70-5808 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No /hd 6 10.2 Funeral Directo rein 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6954 ark 20170 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0, 1 ☐ Yes 2 No Black Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumating security. Elementary/Secondary (0-12) College (1-4or 5+) ployed 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Be 050 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3807 Uchmond Ca. 23227 Chamberl ayne 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition XBurial 2 ☐ Cremation 3 Removal from State Mt. Calvary \* 4 ☐ Donation 5 ☐ Other (Specify) 22 Yame and Address of Famility 21. Signature of Funeral Service Licensee ungral PDC9. ltos au 23a. Part1. Enter the disease, or complications that cauded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and the for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 X Yes Yes 2 🗌 No 2 ☐ No 25. Was case referred to medical examiner?

1 4 es 2 No Be 26. Place of Death (Check only one) Hospital: Other: 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To the funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury atter death. 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 Homicide within 24 hours a To the Funeral i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 286. Signature and title of certifier 29c. License number O.C.M.E. December 01, 2004

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2004 A. ...

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sporks

111 Penn Street, Baltimore, Maryland 21201

Registrar

State of Maryland / Department of Health and Mental Hygiene () () i.

30336

					Ce	rtificate of l	Death	R	eg. No.	J 4	30330
	Physici		Decedent's Name (First, Middle, Las	" Studin	rger			2. Date of Dee Month	th Day Of	Year Pool (	3. Time of Death 12.30 AM
-	/Medic Examin		4a Facility Name (If not institution, give	street and number)	<u> </u>	4	lb. City, Town, or L	NOVEWU	4c. County of		,
	Examin		MANOR CARE NO	IRSING Home	2		Tow	SON	B	ALT	nere
	Funeral		Social Security Number     6. S	ex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthpl	ace (State or Foreign
	Director		134-10 00/1	□M 2DF 8	9 Yrs.			July 31,	1915		"NJ.
	and and		Usual Residence of Decedent  10a. State 10b. County	. 10c.	City, Town or Lo	ocation				10	d. Inside City Limits
	Mary	ō	MD BAL	TIMORE		PARKUI	110				1 ☐ Yes 2 No
	h the	<u>s</u>	10e. Street end Number			10f. Zip Code	110	1	0g. Citizen of W	hat Count	ry?
	23a C	a D	7846 WESTM	oreland Av	e	2	1234		0.5	A	
	r dea	Iner	11. Maritel Status	12. Was Decedent Ever in Armed Forces?	U,S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No- Rican, etc.)		- America	
20	ba filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28e-f show event, the Madical Examinar must be notified at	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□ Yes 2□ No	Specify:	,	Specify:		
5-0020	72 hot	eted	15. Decedent's Ed (Specify only highest gra	ucation		dent's Usual Occupa		ina	16b. Kind of Bus		
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7	Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	NIA		ASSem(	18. Mother's Name	First Middle A	SOUP		۲.
Maryland	d ba ental ced o	To Be	Unknown	<b>1</b>				Known	naideir durname	"	i
<u>2</u>	shound Mind	۲	19a. Informant's Name/Relationship (7	-	19b. Mailir	ng Address (Street a			City or Town, S	State, Zip	Code)
	alth a 27 ts		DOROTHY GO	CAMCO	1846	6 Westin	oxeland	Ave, B	alto. Mus	213	34
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altimore,	Peges ment of ant: If Its ury or o		_1 Burial 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	ULANCY	VALLEY	cem.	2/1/04	Balto	. Ms	e
ğ	parmit. Departr Importu any Inj		21. Signature of Funeral Service Licens		22	2. Name and Addres	s of Facility	Tella Fu	neral	Home	CHTD.
ш	205 # 2		Vaul M	Stella	7	527 has	FORD RD	Bolto	MD212	34	
			23a. Part1/Enter the disease, or composhock, or heart failure. List only of	lications that caused the de						1	Approximate Interval Between
)	Physician /Medical		Immediate Cause (Final	G.	1.	0 -	1 0	-			Onset and Death
	Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Tyo Ca. Due to	rdia	( 9m	farel	loy		1	ers men
П		Je.		4 1 1	(or as a conseq	quence of):	2 -1.			2	Less Then 4 hours
	outed Id ansit	Ĕ	Sequentially list conditions	b. Mioru C	(or as a conseq	mence of).	Janu	ne			
Ď,	a axedian ar	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury		(0.100 - 0.000	,				į.	
09/90	ertificate ba axecuted ling physician and ie es the burial-transit	edical Examiner	that initiated events resulting in death) Last	Due to	(or as a conseq	uence of):					
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0	daath c le attenc ed for us	Physician	David Other design and sent								
į	tha d by the achec	nys	Part II. Other significant conditions co	ntributing to death but not re	esulting in the ur	nderlying cause give	on in Part I.				the cause of death?
Ľ	s that med t	Dy P						1 🗆 🕶	s 2□No 3	3 🗌 Probi	ibly 4 Ayonkhown
ords,	raquiras thet tha veen signed by th hould be detache	8						24a. Was ar	autopsy	24b. Wer	e autopsy findings lable prior to
	law ra as be	Completed						porrom		com	pletion of cause eath?
<u> </u>	Tha law ata has b page 2 s	000						1 □ Ye	s 21 No	1 🗆	Yes 2000
2	clan: ertific ector,	Re	25. Was case referred to medical examiner?				26. Place of Death	(Check only one	9)		``
5	hysic this c el din	2	1 ☐ Yes 2 ☐ No 27. Magner of Death		☐ ER/Outpatien		4 Nursing Hor	me 5□ Reside			
5	ding i	01	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? /es 2 □ No	28d. Describe ho	w injury occurred	d	
	Attending Physician: or death. octor: After this certific by the funerel director.	IICa	3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, stre			28f. Location (Str	eet and Number	or Rural	Route Number,
Ś	s after	Certification:	4 ☐ Homicide	building, etc. (Spec	city)			City or Town			
		edicai	29a. Certifier (Check only 2 Medical Exami	sician: To the best of my kr ner: On the basis of examin	nowledge, death	occurred at the time	e, date and place, a	and due to the ca	use(s) and man	ner as sta	ted.
	the thin 2 the f		Orie)	and manner stated.							
	\ 5. <u>¥</u>	-	29b. Signature and title of certifier	Torpu	an	$\sim$ $\mathcal{D}^{29c.\ License}$	0661	1	Over	el &	2004
	h		30. Name end address of person who so	ompleted cause of death /Ite	em 23a) (Tuna I	Print).		F 0 0	d. Date signed of Overwhelm	7 -	0
	9			ever Bl	va,	Balti Louis	well.	red	义()	1-5	7 ^
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	Registra	r a	DEC 0 3 2004	homen	D.	sporks					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 004 38337 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Stanley Sufczynski, Sr. Μ. Nov. 11:50P 28,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7310 Waldman Avenue Baltimore Edgemere If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2 □ F Months 71 218-28-8762 Director 4,1933 Maryland April Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location r than "naturel", or itams 23a or 28a-f show the Medical Examinat must be notified at 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes ŽTNo Edgemere Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7310 Waldman Ayenue 21219 death United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. Int: if item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Policeman Steel Industry traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Melchoir Sufczynski Caroline Ichnowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Stanley M. Sufczynski, Jr. 1732 Manor Rd. Dundalk, Maryland 21222 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 12/2/2004 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. Hilltop Service Corp. \* 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Luda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOMYDRATHY Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any learning to an accuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine sician and burial-transit ре ехес Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. the detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ PROSTATE 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl. one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 🗷 No ၉ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: ospital or Attending hours after death. Division 5 Pending investigation 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitai within 24 hours a To the Funerel D 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the Tagis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 038635 - SA 30 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH PT. RD. FORT HOLINAD MX 21052 9600 KISHORE UDYAVAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 3 2004

		For State Registrar  1. Decedent's Name (Firs	t Middle Last		Marylan		artmen rtificate				ental Hyg	g. No.	00	4 3	<del>333</del> 8
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		Genesis E		e – Spa	Creek		Anna					An	ne Aı	cundel	
Fune Direc		5. Social Security Number 205–26–4804 Usual Residence of Dece	1111	7. ]M 2□F	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.	8. Date of Birth (Month, Day, Sept. 4	,193	9. 2 Pe	Birthplace (Si Country) ennsy1v	ate or Foreign rania
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5-0036 72 hours after death with the Maryland nature!; or items 23e or 28e-1 show	Manufactures of notified	3 ☐ Widowed 4 ☐ D	<b>X</b> Married	Armed Force  1 XYes 2 if Yes, Give  Year or Date	es? □No		f Yes, special		Specify:	, Puerto F	cify Yes or No- Rican, etc.)			white, etc. White	in,
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larylan 2 should be and Menta Is marked	To	19a. Informant's Name/R		pe. Print)		19b. Mailie	na Address	(Street a			Route Number,		own Stat	e Zin Code)	
Ma nd 2 s allth ar 27 ls		Margaret R.		, ,	e)	1	_				r, MD 21		own, olui	o, Ep oddoj	
or Hear	9010	20a. Method of Disposition				lace of Dispo emetery, crei	sition (Nan	ne of ther place	9)	Da	ate 2	0c. Loca	tion - City	or Town, Sta	е
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Baltimore, permit. Pages 1 a Department of Hee Importent: If item	any in	21. Signature of Funeral	Service License	alder	the	22	Hard 12 R	esty	Fune	ral 1	Home, P.	A. olis	. MD	21401	
ate be executed Sample of the hybridian and the hurial-fracett sample of t	cal Examiner		<b>(</b>	Due to (or		uence of):	LM	JG	CAN	ZGR					I Between and Death CHTMS
death certitic death certitic	ion use as	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 □ Yes 2 □ No 9 □ Unknown	Idirii	3c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknowr	2 Fetal	death 3	Ectopic pre					230	d. Date of Month	delivery Day	Year
ecords, P.O. law requires that the as been signed by th	2	Part II. Other significant	conditions con	tributing to deat	h but not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did toba			to the cause Probably 4	
Vital Records, sicien: The law requires t certificate has been signe										_	24a. Was an autopsy perform			autopsy findi to completion 1? 'es 2 No	
ien: Sien: Britilica	Be C	25. Was case referred to	medical						26. Place	of Death	(Check only one				
On of ding Phys Atter this		1 ☐ Yes 2 No	Pending investigation	1 Inpa 28a. Date of Info		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	Nur		e 5 Resider 3d. Describe how			pecify)	
DIVISION C To the Hospitel or Attending P within 24 hours after death To the Funerel Director: Attent Tromplately filled in by the funers	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of building,	Injury - At ho etc. (Specify	me, farm, str	eet, factory,	, office		28	Bf. Location (Stre City or Town,	et and N State)	lumber or	Rural Route	Number,
To the Hospitel within 24 hours a To the Funerel I	pretery unit	29a. Certifier 1 X C (Check only 2 N one)	ertifying Phys ledicel Exemin	sicien: To the be ner: On the basis and manner	s of examinal	wledge, death ion and/or in	occurred a restigation,	at the time in my op	e, date and inion, death	f place, ar h occurred	nd due to the cau d at the time, dat	use(s) an	d manner ace, and c	as stated. due to the cau	se(s)
To the within 2 To the complete		29b. Signature and itle of	certifie	Daro (	an		,		0364		,	Dec	2,		ur)
3		3/. Imme and address of	person who co	MD,	900 '	23a) (Type, SESTO	Print)	B	300	Am	MAPONS				
·Reg	State gistrar	31. Date filed (Month, Da)	3 2004	32. Regi	strar's Signal	ture App	de								

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 29, 2004 November 11:50 AM Shea Eleanor L. /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Layhill Center-Genesis Health Care Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) May 3, 190 Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 🕱 F Yrs 1902 Washington, D.C. Director 102 <u>578-62-2550</u> Usuel Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Funeral Director Silver Spring <u>Maryl</u>and Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 20906 United States 3227 Bel Pre Road 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: þ Specify. 3 ☑ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Internal Elementery/Secondery (0-12) College (1-4or 5+) Revenue Service 12 Secretary 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eva May Harner John Henry Luthy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4998 Battery Lane #515, Bethesda, Maryland 20814 Helen Leary/ Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition December December 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 2, 2004 Suitland, Maryland Cedar Hill Cemetery 22. Name and Address of Fecility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 21. Signature of Funeral Service Licens M01405 Bethesda, Maryland 20814 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Hypertension Examiner Due to (or as a consequence of): Physician/Medical Examiner Anemia ettending physicien end of for use as the bunel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? ete hes been signed by the page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed within 24 hours effer death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 21 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) Certification: 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred injury Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide In certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es stated.

| Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier cal (Check only one) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 36 80 skAugra, MD 04

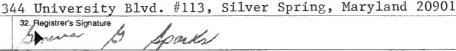
State

Satish Angra, M.D.

31. Date filed (Month, Dey, Yeer)

DEC 0 3 2004

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)



Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38340 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARIE D. Year SCHREIBER Docember 11'.17 AM 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glan Burnie North Grundel Vespital Anne arunds If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 219-18-5000 Director Yrs. 79 15, 1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and them 17 is marked other then "naturel", or Items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits irel', or Items 23e or 28a-f show Exeminer must be notified at Maryland Anne Arundel Pasadena Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1700 Twickenham Rd. 21122 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by Specify: 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Long Distance Operator C & P Telephone Co 8 0 traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leo Buenger Wilhelmina 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann McIntyre (Dtr.) 1031 Deep Creek Ave., Arnold, Md. 21012 20b. Place of Disposition (Name of cametery, crematory or other place)
Glen Haven Mem. Pk. 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Deportment of H Important; If its any injury or otl 1 Denoval from State 12/4/04 Glen Burnie, Md. ¹ 4 □ Donation 5 □ Other (Specify) 21. Signatur, of Fundal Service Licensee Kevin E Ecker<sup>22</sup>. Name and Address of Facility McCully-Polyniak Funeral Home, P.A 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician tailuxe disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit ccaquiageth that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, respiration tailure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should (oncertive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2**X** No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Panpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Puneral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type Print) 30. Name and address of person who can Dr. Glen Burnie, MB 2106 CTUBRE JACOBS MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 03 2004

Amend item#22, perFH, 6838, 12/6/04 The Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 4:45 PM **Physician** Ruth W. Smith November 25, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hospital of Baltimore Baltmore Sinal If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 22, 1927 5. Social Security Number **Funeral** 1 ☐ M 2 🂢 F 217-22-6424 77 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Item 27 is marked other than "naturel", or Items 23a or 28a-f show other treumatic event, the Neidlest Ever in or minal be notified at 1√ Yes 2 No Director MD Baltimore 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 2218 Braddish Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) teacher education 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be a Mabel Hooper Sherman Ullyses Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permil. Pages 1 and 2 Department of Health an Importent: If Item 27 is any injury or other treu once. 2218 Braddish Avenue Baltimore, MD 21216 Frances Dorsey/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 X Donation 5 ☐ Other (Specify) 22 Name and Address of Facility March West Funeral Home State Anatomy Board 55 W. Baltimore St. Balt 21. Signature of Funeral Service Licensee

Rohald Wade, Direct

23a. art1. Enter the disease, implications that caused the cock, or heart failure. List only one cause on each line. Director Approximate 1215
Interval Between
Onset and Death Baltimore, MB mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 9 days Post-obstructive preumonia **Physician** /Medical Due to (or as a consequence of): **Examiner** all lung cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Hypertension Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Hyperlipidemia Pulmonary 1 Yes Obstructive 25 NO Chroniz 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No efter death.

I Director: Aff of in by the fur 2 🗌 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be n 24 hours efter der he Funerel Directo pletely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) Within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ۵ RES-000 November 25, 2004 Hartman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Baltimore Rachel Hartman, Sinai Hospital M.D. 31. Date filed (Month, Day, Year)
DEC 0 3 2004 32. Registrar's Signature State Registrar

SMITH

			1- For State of Maryland Registrar		artment of H rtificate of		Re	g. No. UU4	38342
	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Lawrence Shoemaker				2. Date of Death Month Novembe	Day Year	3. Time of Death 4 6:50 AM M
	/Medi Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	iun
	Ø.		Stella Maris Hospice	-4 6 into 1 - 3	Balti If Under 1 Year	more If Under 24 Hrs.		Timonium	
	Funeral Director		5. Social Security Number  219-18-2208  G. Sex  1 M M 2 F  7. Age (In yrs. last 1 M 2 F)  81	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 29		thplace (State or Foreign ountry) Lryland
	laryland show	2	10a. State 10b. County 10c. City, MD	Town or Lo	cation Ltimore				10d. Inside City Limits 1X Yes 2 □ No
	the N	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	
	h with	ai Di	6813 Blenheim Road #B			1212	10	USA	ountry :
36	be filed within 72 hours after death with the Maryland that Hyglene.  do other then "naturel", or items 23a or 28e-f show event, I're Medical Excipier , ust be inclified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Apped Forces?  1 Never Married 2 Married  15. Yes 2 No If Yes, Give Year or Dates: 143-4		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
Baltimore, Maryland 21215-0036	nin 72 hou n "nature Medical E	Completed I	15. Decedent's Education (Specify only highest grade completed)	16a, Deced	lent's Usual Occup kind of work done OO NOT use retired	eation during most of work d)	ing 1	6b. Kind of Business	/Industry
77.	filed with Hygiene. other ther ent, Ir e M	Com	unk unk	m	ortgage l	banker		fina	ncial
and E	e d fa d	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, M	aiden Sumame)	
Ĕ	should be nd Mental marked o	우	Dudley Shoemaker  19a. Informant's Name/Relationship (Type, Print)	19h Mailir	Address (Street		nor Mille	City or Town, State,	Zin Codo)
E ∑	is 1 and 2 should of Health and Mer item 27 is marke other treumetic		Carolyn Kennedy/daughter			ıt Avenue			211
More	Pages 1 and the part of the part: If item arry or other		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  '4 ※Donation 5 □ Other (Specify)	ce of Dispos netery, crem	sition (Name of natory or other plac	ca)	Date 2	Oc. Location - City or	Town, State
Balt	permit. Page Department of Importent: If any injury or once.		21. Signatur Funer Type Sicensee Wades Director			ss of Facility Omy Board MD 212		Baltimore	Street
J	Pnysician		23a. Pan 1. Enter the disease or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Do not ente	er the mode of dyin	ig, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequent	nce of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	nce of):					
8/60,	certificate be executed iding physician and ise as the burial-transit	dicai Exa	resulting in death) Last  Due to (or as a consequent of death)	nce of):					
<u>n</u>	death certifi e attending I id for use as	hysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of dea Month	ivery Day Year
ŗ	requires that the een signed by th nould be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting	ing in the un	derlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Sords	w requires been sign should be						1 🗆 Yes	2 □ No 3 □ Pr	obably <sup>4</sup> X Unknown
L Lec	The law ate has b page 2 si	Completed					24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
VII	Physicien: Th this certiticate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:		Othe		(Check only one)		
10 10	ding Phys h. After this tuneral dii	tion: To	27. Manner of Death  1 Natural 5 Pending  1 Inpatient 2 ER  28a. Date of Injury (Month, Day Year)	NOutpatient 8b. Time of Injury	28c. Injury Work	4   Nursing Ho	me 5 Resident 28d. Describe how	ce 6 <b>X</b> Other (Specially occurred	HOSPICE
	el or Atten s after deal of Directors of in by the	Sertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre			28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely tilled in by the tuneral	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle 2 Madical Examiner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time estigation, in my op	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To T To 1	Σ	29b. Signature and title of certifier		29c. License	number 13725	290	Date signed (Month	n, Day, Year)
		1	30. Name and address of person who completed cause of death (Item 23	3a) (Type, F		13165		11/944/	07
			DR. TARIO MAHMOOD 2300 DULANEY 31. Date filed (Month, Day, Year) 32. Registrar's Signature	VALLI	EY RD. I	TMONTUM,	MD 21093	77.2	
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	2500					

DHMH 17 Rev 1/2001

NOVEMBER 24, 2004

LAWRENCE SHOEMAKER

			1 - For State Registrar	10000			land / Dep		nt of H	ealth an		ental Hyg		300	le.	3 8	134	: 3
	Physic	ian	1. Decedent's Name (First, Robert Frank		,						N	2. Date of Death Month November		, 200	<del>Q</del> ar		of Deat	
	/Medi Examii		4a. Facility Name (If not inst Gilchrist Ce	itution, giv		umber)			Town, or	Location of D		NOV EMBET	4c. (	County of	Death		5 a	
	Funeral Director		5. Social Security Number 182–28–6678		ex ☑M 2□F	7. Age (In	yrs. last birthda Yrs.	/) If Under Months	1 Year Days	If Under 24 Hours &		8. Date of Birth (Month, Day Iarch 17	Year) , 1	919	Birthpl Count Pen	ace (Star ry) nsy1	te or Fore vani	eign La
	Maryland f show ied at	ior	Usual Residence of Decede  10a. State 10b. Co			10	c. City, Town or	ocation Air							10	d. Inside	City Lim	
	h with the 23a or 28a at be notif	al Director	10e. Street and Number 2055 Stratto					10f. Zip	Code 1015			10	_	en of Wha				
980	be filed within 72 hours after death with the Maryland tial Hygiene. So other than "netural", or Items 23a or 28a-f show event, the Maryled Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Div		Armed F	2 □ No Sive	in U.S. 13	. Was Deced If Yes, spec			? (Specuento R	ify Yes or No- ican, etc.)		Connifu	America White, e	tc.	,	
21215-0036	vithin 72 ho ne. <b>han "netu</b> i e M. dical	Completed	(Specify only I		de completed	() (1-4or 5+)	16a. Dec (Giv life.	edent's Usua e kind of wo DO NOT us	al Occupa rk done d se retired)	tion uring most of	working	g 1	6b. Kin	d of Busin	ness/Ind	ustry		
and 2	filled Hygi other	Be	12 years 17. Father's Name (First, Mi Harry David				sa1	esman				(First, Middle, M	aiden S	ırnit Gumame)	ure	sal	es	
Maryland	Should be and Menta is marked sumatic ev	ဥ	19a. Informant's Name/Rela	itionship (	Гуре, Print)		19b. Mai	ling Address	(Street a			Morloc Route Number,		Town, Sta	ite, Zip (	Code)		
	1 and 2 Health em 27 I		Robert Harry  20a. Method of Disposition	Treo	n/son	2					., B	el Air,	_	210		un Chaha		
Baltimore,	Pages ment of ant: If it ury or c		1 ☐ Burial 2 ☐ Crema  4 ☐ Donation 5 ☐ Oth	tion 3 [	Removal fron	Julia	Ob. Place of Disp cemetery, cri Bel Air			- 1		4		Air,		ni, State		
l Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.		21. Signature of Funeral Se	ome of	R _ 1	A + +	Tm	2.										
	Physician		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	se, or com List only	olications that one cause on	caused the each line.	ltoda	Icuna	e of dying	mph	diac or	respiratory arres	st,	riu•	210	Olisot all	letween	2
	/Medical Examiner				Due to	o (or as a coa	nsequence of):		•							J		
8760, V	ate be executed hysician and he burial-transit	cal Examiner	Sequentially list conditions, if my leading to mindrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	C	`	nesquence of):											
.O. Box 6	Attending Physician: The law requires that the death certificate be executed ir death. actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			birth 2 🗍 nant at time	Fetal death 3	⊒Ectopic pro □ Other (spe					23	d. Date of Month		/ Day	Year	
rds, P	w requires that been signed t should be deti		Part II. Other significant con	nditions c	ontributing to	death but no	t resulting in the	underlying ca	ause giver	n in Part I.		23e. Did toba				cause of		₩n
Records,	The law re ate has bee page 2 sho	Completed									-	24a. Was an autopsy performe		24b. Were prior death	to comp h?	y finding pletion of	s availat cause o	ole r
Vita	ysician: The l is certificate ha director, page	Be	25. Was case referred to me examiner?	edical	Hospital:				0.11			Check only one				Tomas		
Division of Vital	arding Physath. or: After this ne funeral di	ation: To		vestigation	28a. Date (Mor		2 ER/Outpatie 28b. Time ( Injury		Bc. Injury a Work?	at Norshi	_	5 □ Residen  d. Describe how		Other (S	Specify)	Hos	ice	
Divis	F 9 F	Certification:	4 Homicide de	ould not be termined	build	ling, etc. (Sp						f. Location (Stre City or Town,	State)					
	To the Hospital of within 24 hours of To the Funeral Completely filled in	Medical			/sician: To th iner: On the t and mar	e best of my pasis of exar nner stated.	knowledge, dea nination and/or ii				ace, and ccurred	d due to the cau at the time, date	se(s) ar and p	nd manner lace, and	r as stat due to ti	ed. ne cause	(s)	w o
		-	29b. Signature any itle of ce	the	y l	ly	. mg		License (	1902				signed (Mo			2009	K
	10x1		30. Name and address of per	ley	ompleted cau	se of eath			. Ch	arles	Str	eet Bal	Ltim	ore,	MD.	21	204	
	Sta Registr		31. Date filed (Month, Day, Y	3 200		Registrar's S		do	uks	/								

NOV. 29th 2004 at

TREON, ROBERT

DHMH 17 Rev 1/2001

Registrar

				Please		It in Black in			_	•	
				1 _ For State	State of Ma	aryland / Depa			lental Hyg	jiene no l	2001 =
				- State Registrar		Cei	tificate of	Death	R	leg. No.2 U U 4	38345
				1. Decedent's Name (First, Middle, Last	)				2. Date of Dea Month	th Day Year	3. Time of Death
_		Physici /Medio		Newell	_	VALENT	INC		NOU	28 2006	( 3: 40 AM
		Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Deat	h
				GILLChrest	HOSP	ico	,	Towson		BALTI	MORE
		Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Birtl	nplace (State or Foreign
		Director		219-07-9007	2M 2□F	86 Yrs.	Months Days	Hours Min.	OCI 2	Year) 1918 Co	untry) MD.
				Usual Residence of Decedent							
		yłan how		10a. State 10b. County	94	10c. City, Town or Lo					10d. Inside City Limits
		Mar F-	ģ	MD BALT	There	′	PARKUI	lle			1 ☐ Yes 2 No
		128 128	rec	10e. Street and Number			10f. Zip Code		1	log. Citizen of What Co	untry?
		filed within 72 hours after deeth with the Maryland Hygione. uther than "natural", or Iteme 23e or 28e-f show ent, the Medical Examinar must be notitled at	by Funeral Director	2713 MAPLE	AUC		2	1234		U.S	· A ·
		Jeeth Jeeth	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-	14. Race - Ame	ncan Indian,
2	10	r Ite	교	1 Never Married 2 Married	Armed Forces?	No U.S.			Rican, etc.)	Black, White	e, etc.
ટુ	33	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	ARMY	1 ☐ Yes 2☐ No	Specify:		Specify: W	hite
06:	21215-0036	2 ho	Completed	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occup	pation		16b. Kind of Business/l	ndustry
5.	7.	olo 7	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	life. I	king of work done DO NOT use retire	during most of working)	ng		
3	212	T the	E	1246	N/V	,,,,	MILL	worker		SPARROWS	POINT.
		e filed with al Hygiene. I other than vent, the M	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Sumame)	
	au	id be Ked s	To B	MATHEW VALL	entine			& LIZAB	eth L	chehRhA	N
5	Maryland	2 should be in and Mental is marked or reumatic ever	-	Informant's Name/Relationship (T		19b. Mailir	ng Address (Street			r, City or Town, State, Z	
0	S	nd 2 alth ar		Koth Walent	in wil	E) 2713	MARel	Ave BAL	to. (40 à	21834	
11/28/04	ė,	s 1 and 2 should be filed if Health and Mental Hyg Item 27 is marked othe other treumatic event,		20a, Method of Disposition	nac (ss.	20b. Place of Dispo	sition (Name of			20c. Location - City or	Town, State
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-	믍	permit. Pages Department of Importent: If I any injury or once.		'4 □Donation 5 □ Other (Specify,		PARKWOO	D Cem		101	DA ITE. PU	0.170
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		ED 2 6 G		Jane 100.	> tella	1/5	21 harl	EIX (CO).	100 110, 1	00 0c1079	
	- 11			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each lir	the death. Do not ent ne.	er the mode of dyir	ng, such as cardiac c	r respiratory arr	est,	Approximate Interval Between Onset and Death
		Physician		Immediate Cause (Final disease or condition	Chron	ic OUSTru	ctive Lu	Mg Disea	se		Year's
	7	/Medical		resulting in death)	Due to (or as	a consequence of):					
		Examiner		Sequentially list conditions	b						
(		P ==	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
6	5	be executed ician and burial-transit	Ē	that initiated events	С,						
	ó	be exerician ar		resulting in death) Last	Due to (or as	a consequence of):					
	760,	Attending Physicien: The law requires that the death certificate be executed in death. In death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	cai		d						
	P.O. Box 68	death certificate t attending physic of for use as the b	by Physician/Medi								
	ŏ	andin use	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Date of deli	very
	m	d for	cia	in the past 12 months?	4□Pregnant at		Other (specify)	y 		Month	Day Year
	0	that the de ed by the detached	Jys	9 Unknown	9□ Unknown						
	₽.	uires that signed k d be det	y P	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the ur	nderlying cause giv	ven in Part I.	23e. Did tob	bacco use contribute to	the cause of death?
	Sp.	uires sign	d b	Chronic infi	lamatory	Jemyelinai	tine Poly	y newopath	y 1 Sere	es 2□No 3□Pro	bably 4 Unknown
N	00	w requires been sign should be	Completed						24a. Was a	n 24b. Were auf	opsy findings available
News	Re	has ge 2	Ę.						autons	prior to c ned2 death?	ompletion of cause of
2	<u>e</u>	i <b>cien:</b> Th certificate rector, pag									2 <b>0</b> No
-	V.	certif	Be	25. Was case referred to medical examiner?	Hospital:		t 317 DOA Oth	26. Place of Death			
5	ot o	Phys this al dil	<sup>2</sup>	To res 25grad	1 L Inpatie	nt 2 ER/Outpatien  28b. Time of	1 JE BOR	4   14013111g 1101		ow injury occurred	(fy) Hospice
Ĩ.	Ē	ding f	0	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui (Month, Da)		28c. Injur Wor M 1	rk? Yes 2 □ No	-ou. Describe no	ow injury occurred	
<	Sic	uttendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be					304 Landing (O4		17 1/
alentine,	Division of Vital Records,	F 8 F C	Certification:	4 Homicide determined	building, etc	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office	1	City or Town	reet and Number or Ru n, State)	rai Houte Number,
g		urs e			10			<u> </u>			
-		To the Hospitel or Attending Physicien: The i within 24 hours effer death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exam	iner: On the basis of	examination and/or inv				ause(s) and manner as ate and place, and due	
		the the	Jed	one)	and manner sta	ited.	29c. Licens	o number	20	9d. Date signed (Month	Day Vear)
		or with	-	29b. Signature and title of certifier	21	MD			2.		
		$\wedge$	/	The same	races			61199		Nov 18	2004
		10		30. Name and ardress of person who c	ompleted cause of d	A A		N. Charles	Stroot	Raltim	ore, MD.
				31. Date filed (Month, Day, Year)	22 Pariet	ar's Signature	0001	w. onarres	Pereer	Daterill	21204
		Sta Registi		DEC 0 3 2004	Jacob And	ara signatura	por st 1				21207
		negisti	ell.	DEO 0 0 2004	100	To for	Se Colon				

			1- For Amend Item 26 Registrar	State of Marylan	nd/Pep Ce	artmen 03764 rtificate	tof H dhb e of L	lealth a	and Me	ental Hyg	giene	2001	3834	6
			Decedent's Name (First, Middle, Last)		-		-			2. Date of Dea	ath Day	Yea	3. Time of Death	
п	Physici		Rosalie Theresa	Vinkowski					]	Novembe				A
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City,	Town, or	Location o	of Death		4c.	County of De	ath	
			601 Remington Roa	ad			Fal	1ston	n			Harfo		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birti	h y, Year)	9. B	irthplace (State or Foreig Country)	רון
	Director		212-36-3249	M 2 <b>X</b> F 66	Yrs.	10,000,000		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		July 12		38	Maryland	
	2 >		Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	ocation							10d. Inside City Limits	s
	aryla ehov	_			ny, rown or E		1						1 ☐ Yes 2X No	
	Ba-1	Director	Maryland Harfo	ord		10f. Zip	1sto	n			10g Citis	en of What (	Country?	
	with t	Ö	10e. Street and Number			101. Zip					rog. Oniz			
	sath	Funeral	601 Remington Roa	d 12. Was Decedent Ever in t	18 13	Was Decer		21047	gin? (Spec	rfv Yas or No-	. 1	U. S. 4. Race - An	A .	
	iter d	Ë	1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, spec	ofy Cuba	n, Mexican	n, Puerto R	ofy Yes or No- lican, etc.)		Black, Wh	nite, etc.	
39	urs af	by I	3 ☑ Widowed 4 □ Divorced	1 □ Yes 2 ☑ No If Yes, Give A Year or Dates:		1 Yes	2X No	Specify:				Specify:	White	
ŏ	within 72 hours after death with the Maryland ane. than 'naturel', or items 23a or 28a-f ehow than Medical Examerar must be notified at	Completed	15. Decedent's Educ	cation	16a. Dece	dent's Usua	al Occupa	ation	t of wastin		16b. Kin	d of Busines	s/Industry	
2	hin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of wor DO NOT us	se retired	)	t or working	9				
2	giene giene	No.	8th Grade			Home	make					√n Hom	e	
Maryland 21215-0036	al Hy al Hy I oth	Be (	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,	Maiden :	Sumame)		
<u>a</u>	Ment Ment arked	2	Peter August							ine Gra				
a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examenat must be collined at Once.		19a, Informant's Name/Relationship (Ty)	pe, Print)						Route Numbe				
	and ealth n 27		Leonard W. Vinkows					Road		llston,				
Baltimore,	of H of H if item		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	i i	Place of Dispo cemetery, cre-	matory or o	ne or ther plac	e)	Da	110	20¢. Loc	ation - City o	r Town, State	
Ē	Pages ment of I ant: If its ury or o		'4 ☐ Donation 5 ☐ Other (Specify)		11y Hil	1 Mem	ı. Pa	ark 🗓	11/23	/2004	Balt	imore	, Maryalnd	_
ä	Depart Import eny in		21. Signature of Funeral Service License	30	2:	2. Name an	d Addres	s of Facility	<sup>y</sup> Schi	munek l	Funer	cal Ho	me of Bel A	ir
ш_	20539		1000	te,	Ir	nc., 6	10 W	I. Mac	cphai	1 Rd.,	Be1	Air,	Md. 21014	
Р			23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	ne cause on each line.	/						rest,		Approximate Interval Between Onset and Death	
н	Physician /Medical		disease or condition resulting in death)	metast	anc	lu	nej	Cun	nces					
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	ate be executed hysician and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
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89	leath certificate attending phy I for use as the	ledi	VaWitte											
Вох	h cer andin	Physician/Med	23b. was decedent pregnant	3c. If yes, outcome of pregr 1☐Live birth 2☐Fet		□Ectopic pr	egnancy				2	3d. Date of d	,	
	deat	sicie	in the past 12 months?	4☐ Pregnant at time of 9☐ Unknown		Other (sp						Month	Day Year	
0	at the by the tacher	hy	9 🗆 Unknowń											
	The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	by F	Part II. Other significant conditions con	itributing to death but not re	sulting in the u	inderlying c	ause give	en in Part I.			_		to the cause of death?	
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Records,	ne law re has be ge 2 sho	Completed								24a. Was a	sv	prior to	autopsy findings available completion of cause of	8
	The I	E								perfor	med? 2 X No	death?	s 2 No	
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical				-		of Death	(Check only or				
<b>&gt;</b>	d is	To	examiner?	fospital: 1 Inpatient	EN Outpation	nt B□ DO	Othe	er: 4 🗆 Nu	irsing Hom	e 5XXResid	ence 6	Other (Sp	ecify)	
0 _	ding Phy After thi funeral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	2	8c. Injury Work	at c?	28	3d. Describe h	ow injury	occurred		
0	endir sath. or: Al	atle	2 Accident investigation			М		Yes 2□1	_					
Division of	l or Attencatter death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, st	reet, factory	y, office		28	If Location (S City or Tow		Number or F	Rural Route Number,	
	ital o irs afi raf Di iled ir						285							
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred ivestigation.	at the tim , in my op	ne, date and pinion, deat	id place, ar ith occurre	nd due to the o d at the time, o	ause(s) a late and l	and manner a place, and du	is stated. He to the cause(s)	
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and mainer stated.		290	. License	number		2	29d. Date	signed (Mor	nth, Day, Year)	
	\$ 1 8 1 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		13 /	-			DO	548	41		1	1/22/		
			20 Name of attraction	ompleted cause of death (the	om 22a) /T	Print	0	, ,	-			(	,	
			30. Name and address of person who co	impreted cause of death (ite	O O L	e ninu	Rd	6	2010	AL L	Cin		21014	
170	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	navure	1000			1,8	111	111	-	1011	
	Registr		DEC 0 3 2004	Beneva 1	T 4	souls								

			1 - For State Registrar	of Marylan		artmen rtificate			ind M		giene 0	04	383	47
	Physici	an	Decedent's Name (First, Middle, Last)     LEE WARREN WRIGHT							2. Date of De Month	Day	Year	3. Time of D	eath M
N. Carlot	/Medic Examin		4a. Facility Name (If not institution, give street and n NATIONAL INSTITUTES OF			4b. City. BETH		Location o		NOVEMBE	R 13 200 4c. County MONTG	of Death		
Ī	Funeral Director		5. Social Security Number 6. Sex Unknown 1⊠ M 2□F	7. Age (In yrs. 60	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 10 01	th y, Year)	9. Birthp	lace (State or I try) ita, K	
	ס		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation							Od. Inside City	
	Be-f sh	ctor	KS	M	liotase	2							1∱ Yes 2	2 □ No
	s with the	Dire	10e. Street and Number P.O. Box 161			10f. Zip	Code 7355				10g. Citizen of V USA	/hat Coun	try?	
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28e-f show item 27 is marked other than "naturel", or Items 23a or 28e-f show other treumatic event, Ita Modical Eventrial in the incities of	by Funeral Director	Armed F	2 □ No ive	1		lent of Hi ify Cubai	spanic Origin, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 14. Race Blac	- Americ k, White, Whit	etc.	
21215-0036	hin 72 ho e. an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College	) (1-4or 5+)	16a. Deced (Give life. I	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired,	ition furing most	of worki		16b. Kind of Bu			
d 21	filed wit Hygien ther the	е Соп		yrs.	Light	ting '	[echi				Motion :		re Stu	dio
Maryland	ould be Mental arked o	To Be	Thomas G. Wright							s F. Wa				
Mar	nd 2 sh alth and 27 is m r treum		19a. Informant's Name/Relationship (Type, Print)  Beth Wolf/Sister		1						er, City or Town, KS 6684		Code)	
altimore,	Pages 1 a nent of Hes ant: If item ary or othe		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ Removal from  4 □ Donation 5 □ Other (Specify)	State	lace of Dispo emetery, cren etropol	natory or of	ne of ther place	<sup>9)</sup> 1:	1 <b>-</b> 24	-04	20c. Location - Alexand1	•		
Balti	permit. Pages Department of h Importent: If ite any Injury or of		21. Signature of Funeral Service Licensee	,	40.00						Funeral			
	Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	caused the death each line.  LYMHO (or as a consequence of the consequ	CYTI					r respiratory au	rrest,		Approximate Interval Betwee Onset and De	ath
Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, o	(or as a consequence of pregna birth 2 ☐ Fetal	ncy	Ectopic pre	egnancy		_			of delive	<i>-</i>	
P.O. E	t the dea by the att	hysici		nant at time of de		Other (spe					Mon	th	Day Yea	ar
rds, F	w requires that the death cer been signed by the attendir should be detached for use	ed by P	Part II. Other significant conditions contributing to ALLOGENEIC STEM		ulting in the ur				9V		obacco use contri res 2 No	bute to th 3 □ Proba		
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Division of Vital Records,	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	To Be	27. Manner of Death 28a. Date		ER/Outpatien 28b. Time of Injury		A Othe	r: 4 □ Nur at	sing Hor		ne) lence 6 Othe		)	
Division	I or Attendin after death. Director: Aft I in by the fur	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e of Injury - At ha ling, etc. (Specify	me, farm, str	M eet, factory	1 🗆 Y	es 2□N	_	28f. Location (S City or Tox	Street and Numbern, State)	or Aural	Route Number	r,
	To the Hospitel or A within 24 hours after To the Funerel Director Completely filled in bigging the	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the 2 Medicel Examiner: On the and ma	e best of my know casis of examinat oner stated.	wledge, death tion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the dead at the time, d	cause(s) and mar date and place, a	nner as stand	ated. the cause(s)	
)	To the H within 24 To the F complete	Me	29b. Signature and title of certifier	Q1,0.	$\sim$	29c.	License	number	NE 90	9	29d. Date signed	(Month, E	Day, Year)	
	9		30. Name and address of person who completed cau	-	9		TVF.	ВЕТН	ESDA	MARVI	LAND 208	92		
	Sta Registr		Michael N. Bisho 31. Date filed (Month, Day, Year) DEC 0 3 2004	Pegistrar's Signal				211111		cy amilial	200	<i>,</i> <u> </u>		

	1- For Amend Item 25, 27, 28a-f per me G8427 Registrar Certifi		
Physician /Medical	Karl M. Weygant	M	ate of Death onth Day Yeer 3. Time of Death 11:30 PM  4c. County of Death
Examiner	7979 Holly Road  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Mo	Pasadena Under 1 Year   If Under 24 Hrs. 8, Donths Days Hours Min. (A	Anne Arundel  ate of Birth fonth, Day, Year)  9. Birthplace (State or Foreign Country)
Director	Usuel Residence of Decedent  10a. State  10b. County  10c. City, Town or Location	n	1y 15 1960 MD  10d. Inside City Limits 1 □ Yes 2 ⋈ No
with the M s or 28e-f ke notified Directo		Pasadena or. Zip Code	10g. Citizen of What Country?
Baltimore, Maryland 21215-0036  Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23e or 28e-1 show any injury or other traumatic avent, Ite Medical Examination of the same once.  To Be Completed by Funeral Director	1 Never Married 2 Married 1 XYes 2 No	21122 Decedent of Hispanic Origin? (Specify Ys, specify Cuban, Mexican, Puerto Rican Yes 2 🗓 No Specify:	USA  (*es or No- , etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
Baltimore, Maryland 21215-0036 Semit. Pages I and 2 should be filed within 72 hours att Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic avent, Ite Medical Exami- once.  To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) (Give kind life. DO N	s Usual Occupation of work done during most of working NOT use retired) ter Technican	16b. Kind of Business/Industry
aryland 2 should be filed and Mental Hygis marked other umatic event, II	17. Father's Name (First, Middle, Last) Clifford D. Weygant	18. Mother's Name (Firs	t, Middle, Maiden Surname) Miller
9, Mar I and 2 sh teelth and im 27 is m her traum	Krystal N. Collison (daughter) 25415	Trunk Line Rd., H	enderson, MD 21640
Himore iii. Pages i arment of Portent: If Ite ortent: If Ite injury or ot b.	1 □ Burial 2 ▼ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Metro Cremator	ntory Inc. Dec. 0	Baltimore, Maryland allings Funeral Home, P.A.
Balti Bantit. Depart Import any inje		11 Mountain Road, I	Pasadena, Md 21122
The law requires that the death certificate be executed the hes been signed by the attending physician and cage 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	TIL APPROVED YM	Orisal and Daam
, P.O. Box 68 that the death certifica that the death certifica that by the attending ph detached for use as the y Physician/Medit		opic pregnancy er (specify)	23d. Date of delivery  Month Day Year
cords, P w requires that s been signed b should be deta	Part II. Other significant conditions contributing to death but not resulting in the undert		3e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Vital Record icien: The law requi certificate hes been s rector, page 2 should	winary that west un	1	4a. Was an autopsy findings available prior to completion of cause of death?  ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
~ × × 0	25. Was case referred to medical examiner?  1  Yes  27. Manner of Death  1  Inpatient 2  ER/Outpatient 3  27. Manner of Death  1  Accident	K 28c. Injury at 28d. D Work?	ck only one)  5
Division of  To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification; 7	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, for building, etc. (Specify)  Apartment complex sw  29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investign.	urred at the time, date and place, and do	ocation (Street and Number or Sural Route Number, ity or Town, State Tain Court Apts. hart Rd. & Crain Hwy., Glen
To the Hospitel within 24 hours to the Funeral completely filled Medical Ce	29b. Signature and title of certifier  About Mark Lish Ms	29c. License number	29d. Date signed (Month, Day, Year)
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print (1966) (August 1967) (Type, Print 1966) (Ty		

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

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						Ce	rtificate	e of	Death	1		Reg. N	0.			
			1. Decedent's Name (First, Middle	e, Last)							2. Date of D				3. Time o	of Death
	Physic		Eleanor	re Marie	Will:	ard			November 2				9	2004	8.4	5 AM
1	/Medi Exami		4a. Facility Name (If not institution	n, give street and nu	ımber)				4b. City. To	own, or L	ocation of Dea			y of Death	0.43	7 211
-1	Exami	ner		_												
			Rebecca House			_	If I leadon	1 1/222	Poton		Montgomery					
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 💢 F		rs. last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, E August	irth Ja <i>y,</i> Yea <i>i</i>	)	9. Birthpl Count	ace (State ( try)	or Foreign
	Director		115-18-4044	1LM 2LXF 86		5 Tis.					August	12, 1	918	New Y	őrk	
	p ,	]	Usual Residence of Decedent		1				-							
	lanylan show	_	10a. State 10b. County		10c. (	City, Town or Lo	cation							10	0d. Inside C	ity Limits
	Me P	읝	Maryland   Montg	omery	N	orth Po	tomac								1 ☐ Yes	2 <b>]</b> [] No
	1 28 g	T.	10e. Street end Number				10f. Zip (	Code				10g. C	tizen of	What Count	try?	
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or Items 23e or 28e-f show event, the Medical Examinar must be notified at	Funeral Director	5 War Admiral (	Court				20	878			Und	+ - 4	Ctata		
	leath	era	11. Marital Status		edent Ever in	115 133	Was Deced			ain2 /Co	acifu Vac or N			State ce - America		
	le le	5.	1 Never Married 2 Marri	Armed Fo	orces?	10.	f Yes, speci	fy Cub	an, Mexicar	n, Puerto	ecify Yes or N Rican, etc.)	0-		ick, White, e		
20	s af		3 Midowed 4 □ Divorced	If Yes, Gi	ive		1□Yes 2	₩ No	Specify:				Specia	هٔ: Whi	+0	
8	hour je il	Completed by		Year or D	Pates:									, MIIT	.Le	
5	72 'net	ete	15. Decedent (Specify only highes	l's Education et grade co <i>mpleted)</i>		16a. Deced	dent's Usual kind of work DO NOT use	Occup k done	ation during mos	t of work	ina	16b. F	(ind of E	lusiness/Ind	ustry	
7	within ene.	臣	Elementary/Secondary (0-12)	College (				e retired	d)							
Ŋ	filed w Hygier ther th	Ö	12			Homer	naker					0	wn I	lome		
b	E to the second	Be (	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Nam	e (First, Middle	, Maider	Surnar	ne)		
ā	lid b sents ked ice	To E	Walter Tilley						An	na A	Amesse					
3	2 should be f and Mental I is marked of eumatic eve	_	19a. Informant's Name/Relationsh	nip (Type, Print)		19b Mailir	Address	/Street			al Route Numb	or City	or Town	State 7in /	Code 1	
Maryland 21215-0020	d2: thar 7 is treu		Eugene S. Willa													0070
	ss 1 and 2 should of Health and Men item 27 is marke other treumatic	3	20a. Method of Disposition	.ru / 5011	0.04					, N	orth Po					18/8
ō	Pages nent of H int: If ite		1 🕅 Burial 2 ☐ Cremation	3 □Bemoval from	State 200.	Place of Dispo cemetery, cren	natory or oth	e or ne <i>r pl</i> ac	ce)	D	Date ecember	20c. L M i d c	ocation	City or Tow Villag	m, State	
<u>=</u>	Pag nent ant:		4 □ Donation 5 □ Other (Sp		St	. John'	s Cem	ete:	ry	1	1, 2004	New	Yor	k k	5E,	
Baltimore,	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Septce L	icense	1	_ 22	. Name and	Addre	ss of Facilit	v						
Ď	Depa Impo any It		Jan J. A.	1	+ MOI	Rot	oert A.	. Pun	nphrey	Fune:	ral Home	/Rock	vill	e, Inc.	,	
			you garage	Wanah		305 300	) West	Mont	gomery	Aven	ue, Rock	ville	, Ma	ryland	20850-	-2805
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that on only one cause on e	eused the dea ach line.	ath. Do not ente	er the mode	of dyin	g, such as	cardiac (	or respiratory e	rrest,		ii	Approximate Interval Bety	e ween
	Physician														Onset and E	Death
~	/Medical		Immediate Cause (Final disease or condition	Seps	sis											
	Examiner		resulting in death)	a		(or as a conseq	uence of):	-								
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	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunel-transit	Examiner	Para control for control	<b>b</b> . 11160												
~	exec n an iel-tr	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to	(vi as a Consequ	derice or).							1		
9	sicia bur	ā	Cause (Disease or injury that initiated events	C												
8	phy:	퓿	resulting in death) Last		Due to (	or as a consequ	ience of):							ĺ		
ox 68760,	ding Se es	an/Medical		d										1		
$\simeq$	ath c ttenc	ian														
~	ed f	Physici	Part II. Other eignificent condition	ns contributing to de	ath but not re	sulting in the un	derlying ceu	use give	en in Part I.		23b. Did	tobacco	use co	ntribute to t	he cause c	of deeth?
<u>о</u> .	by t	اچّا	Ch	D 1		ъ.								3 Proba		
ر <u>ن</u>	s tha	by	Chronic Obstru	ctive Pul	monary	Disesa	se, N	orm	al			100 2	23 140	0 . 1000	<b>U</b> , 4□ (	JIRHOWII
ğ	uire Id b										24a. Was	en eutor	nev.	24b. Were	eutopsy fi	indinas
<u></u>	bee shot	Completed	Pressure Hydro	cephalus,	Demen	tia					perfo	rmed?	,	avail	able prior to pletion of ca	0
ě	has e 2	립												of de	ath?	
=	The gate	Ö									10,	Yes 2	oN 🖸	1 🗆 🕆	Yes 2□1	No
===	ien: rtific ctor,	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	ne)			= -,	
Division of Vital Records,	yslc is ce dire	2	1X Yes 2 No	Hospital: 1 □ I	npatient 2	] ER/Outpatient	3□ DOA	Othe	or: 4□ Nur	sing Hon	ne 5□ Resid	dence 4	XIOH.	er (Specify)	Assiste	≥d
0	y Ph erah		27. Manner of Death	28e. Dete	of Injury h, Day Year)	28b. Time of	280	. Injury Work	et		28d. Describe I				TATUE	
ō	t A t	윤	1 🖾 Natural 5 🗆 Pending 2 🗆 Accident investiga		n, Day Year)	Injury	м		∷? Yes 2∐N	lo						
2	ctor y	Certification:	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place	of Injury - At h	nome, farm, stre	et factory o	office		2	28f. Location (S	Street an	d Numb	or or Rum I F	Zouto Alumi	hor
2	or A	T	4 ☐ Homicide determin	buildir	ng, etc. (Speci	fy)	o., .ao.o.,, c	,,,,,			City or Tov	vn, State	)	er or riurarr	IOUIB IVUINL	161,
1	pital ours arai		20n Codilina and a	Dt												
	Hos Fun tely	edicai	(Silcon of a) Z Medical E	Physicien: To the xeminer: On the be	isis or examina	owledge, death ation and/or inve	occurred et estigation, in	the time my op	e, date and inion, death	place, a	nd due to the	ceuse(s) date and	end ma	nner as state	ed.	
	To the Hospital or Attending Physicien: The law requires that the deat within 24 Hours after death.  within 24 Hours after death.  completely filled in by the funeral director, page 2 should be detached to	Med		and mann	er stated.								r.000, 6		54456(3)	
. 1	<b>6 ₹ 6</b> 2	~	29b. Signature and title of certifier				29c. L	icense.	number			29d. Dat		Month, Da	•	
	7		1 Glad	1-12	11	w		) 00	0093	17			111	29/2	66 4	
,	ci,	-	30. Name end eddress of person w	D. Name end eddress of person who completed sause of deeth (Item 23a) (Type, Print)  Polic R.+ F. Byrn E 2333 F. NASHST. A.L.LINGTON, VA 22202  1. Date filled (Month, Day, Year)  32 Benistrar's Signature												
	1.2			BYRNE	2777	J. 1100	45T.	1	2LTmr	TON L	A 222	02				
	Sta		31. Date filed (Month, Day, Year)	32 B	egistrar's Signa	ature		,	To- P	-						
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			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment rtificate			and M	ental Hy	giene	00	14	38350	)
	Physic	ian	1. Decedent's Name (First, Middle,			-				2. Date of De. Month	ath Day	,	Year	3. Time of Death	
	/Med		HELEN  4a. Fecility Name (If not institution,			4b. City, To		Landina		Decemb			004	2:10A	<b>М</b> —-
1	Exami	ner	Homewood Nurs		r	1		more			4C.	N/	of Deeth		
	Funeral		5. Social Security Number 6	. Sex 7. Ag	e (In yrs. last birthday)	If Under 1	Year	If Under a		8. Date of Birt	h Yaas)	-	9. Birthp	lece (State or Foreig	gn
	Director		212-56-8268	1□M 2)QF	52 Yrs.	Months	Days	Hours	Min.	8. Date of Birt 1 a y 1 7	119	52	Mar	yland	
	e Maryland a-f ahow lifted at	ctor	Usuel Residence of Decedent  10a. State 10b. County N /	A	10c. City, Town or Lo								1	0d. Inside City Limits	
	or 28	Dire	10e. Street and Number			10f. Zip C	ode		-		10g. Citiz	zen of W	/hat Cour	itry?	_
	s 23e	ra	1639 Ramblewo				2123					ted	Sta	tes	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f ahow mayortant: If item 27 is marked other than "hadical Examinating the notified at 2008.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1	No	Was Deceder If Yes, specify 1 ☐ Yes 2			jin? (Spec , Puerto P	cify Yes or No- lican, etc.)			k, White,	an Indian, etc. ack	
5-0	72 h "natu	etec	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	dent's Usual (	Occupet done du	tion uring most	of workin	a	16b. Kir	nd of Bu	siness/Inc	dustry	_
121	filed within Hygiene. Ither than "	ld m	Elementary/Secondary (0-12)	College (1-4or 5	Labo	kind of work DO NOT use	retired)	J			ฟิลา	rahi	ouse		
Maryland 21215-0036	ld be filed ental Hygi ked other Ic event, I	To Be Completed	10 17. Father's Name (First, Middle, La Walter Tolbe							(First, Middle, Garr	Maiden :				
	1 and 2 should Health and Men em 27 is marke		19a. Informant's Name/Relationship Shannon White		19b. Mailir 1639	ng Address (S Ramb	Street ar	nd Number	r or Rural Roa	Route Numbe d Balt	r, City or	Town, S	State, Zip MD	Code) • 21239	
ore,	es 1 a of He of He rothe		20a. Method of Disposition		20b. Place of Dispo				ec.Da	the second second second			City or To		_
Ë	Pages ment of I ant: If its ury or o		1 🔀 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	city)	Mount Zi	lon Ce	em.		200	4	Balt	imo	ore,	MD.	
Baltimore,	permit. Pag Department Important: I any injury o		21. Si natur of Funeral Service Lic		Ç <sup>2</sup>	Name and A	Address L O X	of Facility Will 1165	liaT	s Fun timor	era	1 S	eryi	58, P.A	
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	a. ONG  Due to (or as a c.	a consequence of):									Approximate Interval Between Onset and Death	
P.O. Box 6	at the death certific by the attending p tached for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 manths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregr Other (speci	nancy fy)				23	3d. Date Mont	of deliver	y Day Year	
	quires that n signed b uld be deta	Completed by Pl	Part II. Other significant conditions  END STAGE	contributing to death bu	it not resulting in the ur		se given	in Part I.						cause of death?	
900	aw requits ts been s 2 should	plete	ATRIAL FLI	ITTER.						24a. Wasa		24b. We	ere autop:	sy findings available	
B	The ate h	E								autops	ned?	pri de	or to com ath?	pletion of cause of	
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				2	26. Place o	of Death /	1 Yes 2	e)		Yes 2	LEPNO	
of \	hys this	၉	1 ☐ Yes 2 ❤️No		nt 2 ER/Outpatien	t 3 DOA	Other:	4 Nurs	ing Home	5 Reside	nce 6	□Other	(Specify)		
Division of Vital Records,	ding h. After fune	Certification:	27. Manner of Death  1 Matural 5 Pending 2 Accident investigati 3 Suicide 6 Could not		Year) 28b. Time of Injury		Work?	it os 2 □ No	28	d. Describe ho	w inju <i>r</i> y	occurrec	t		
Divi	irection by		4 Homicide determine	building, etc.						City or Town	, State)			Route Number,	
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	29a. Certifier 1	hysician: To the best o miner: On the basis of and manner stat	examination and/or inv	occurred at the estigation, in	he time, my opin	date and l	piace, and occurred	d due to the ca at the time, da	iuse(s) ai	nd manr lace, an	ner as stat d due to t	ted. he cause(s)	
١	To To	2	29b. Signature and title of certifier	7	2.40		cense n		, -				Month, Da		-
•	3		30 Name and address of pareon who	completed cause of de	oth (ltn= 00a) (T 5	2-1								2, 2004	
			LORRAINE OFOX  31. Date filed (Month, Day, Year)			LUCH	4701	בשט ו	EST NY	15176	- 1/M	OKL	, M	21239	<i>r</i> -
1	Sta Registr		DEC 0 3 2004	32. Registra	s Signature	·									

			1 - For State Registrar	State of Maryland / [	Department of Health an Certificate of Death		ene g. No.2004 38351
	Physic	an	1. Decedent's Name (First, Middle, Last			2. Date of Death Month	
	/Medi Exami		FRECIENT C/C 4a. Facility Name (If not institution, give	Willi Ams	4b. City, Town, or Location of E	Novembe:	r 24, 2004   1146 a M
1	LXaiiii	ICI	Johns Hopkins Ho		Baltimore	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	40. County of Death
	Funeral Director		019 20 1763	W. OFF		Hrs. 8. Date of Birth (Month, Day,	
	land ow		Usual Residence of Decedent  10a. State  10b. County	10c. City, Town	n or Location		10d. Inside City Limits
	a-fsh	tor	M.D Ma	Bart	1 mont		1 Yes 2 □ No
	or 28	Direc	10e. Street and Number	0 /	10f. Zip Code	10	g. Citizen of What Country?
	death with the Maryland ms 23a or 28a-f show mast be notified at	Funeral Director	208 South Spain	12. Was Decedent Ever in U.S.	2123)		U.S.A
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23a or 28a-1 show with injury or other traumetic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Tyes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  1 ☐ Yes 2 ☑ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Blac/c
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a.	Decedent's Usual Occupation (Give kind of work done during most of	working 1	6b. Kind of Business/Industry
121	within ene. then "	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of life. DO NOT use retired)	g	5/1/1/1
<u>d</u> 2	filed Hygi other	Be Co	17. Father's Name (First, Middle, Last)	0	18. Mother's	Name (First, Middle, M	School Syskm aiden Sumame)
/lan	ould be Mental sarked o	To B	Edward LEE		Mar	1 UNKnows	1
Maryland	2 sho and I is ma	ľ	19a. Informant's Name/Relationship (T)	rpe, Print) 19b.	Mailing Address (Street and Number 6	r Rural Route Number.	City or Town, State, Zip Code)
	1 and Health em 27		CARELYN WILLIAM  20a. Method of Disposition		Disposition (Name of	FIMULE MANY	oc. Location - City or Town, State
Baltimore,	Pages ent of nt: If it ry or o		1 Surial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State	y, oromatory or other places		BALLIMA MP
altii	permit. I Departm Importar eny injur		21. Signature of Funeral Service Licens		22. Name and Address f Facility		
8	88 58		Vature &	but	1129 N. CARULINE		
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	. Complication	ns of Chroni		0
Ţ,	Examiner			Due to (or as a consequence of	of):		
	÷ 0	iner	Sequentially list conditions, the sequentially list conditions, the sequential sequentia	Оне to (от яв а фольенувалией о	标		
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o	<i>(</i> F) <sub>2</sub>		
68760,	sician buria	alE		200 (0) (3) & 201/354231108 (			
	tificate ng phy as the	Medical					
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
4	res that the igned by be detaction	by Ph	Part II. Other significant conditions cor	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
ords	w require been sig should b					_ 1 □ Yes	2 No 3 Probably 4 Unknown
Records,	has ben pe 2 sho	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
			OF Was seen referred to a dist			1 Yes 2	No 1 XYes 2 No
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  Yang Yes 2 No	lospital:	Oth	Death Check only one)	ce 6 ☐ Other (Specify)
n of	ding Phys h. After this funeral di	T:uc	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury 28b. Ti		28d. Describe how	
Division	en eat part he	catle	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No		
Divi	for Attendate death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At home, fan building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
	To the Hospitel or Att within 24 hours after de To the Funerel Direct completely filled in by the	edical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time, date and player investigation, in my opinion, death of	ace, and due to the cause courred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		29c. License number	29d	. Date signed (Month, Day, Year)
	X		· Carol Ha	llannd	OCME		November 25, 2004
	Α,		30. Name and address of person who co	mpleted cause of death (Item 23a) (1	111 Penn Stro	et, Baltim	ore, Maryland 21201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	4 10-1.		_
	Registr	ai.	AND TO SE CI	101	& sparks		

		•	For State Registrar	State	of Marylan	•	rtment of F		Mental Hyg	iene g. 12. 0 0 1	ş.	38352
			Decedent's Name (First, Middle	le, Last)					2. Date of Deat			3. Time of Death
	Physicia		Melissa	Elaine	Yourkov	ik			Novemb	er 29 20	04	1:10 P M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and no	umber)		4b. City, Town, o	r Location of Dea	th	4c. County of	Deeth	
	LAGIIII		216 Coronet	Drive			Linthic	um		Anne Arundel		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs		Year) 9	. Birthpl Coun	ece (State or Foreign
	Director		212-88-5110	1 □ M 2 <b>X</b> □ F	43	Yrs.	Wild and		Dec. 4,	1960   2	Zama	, Japan
	۵ م		Usual Residence of Decedent  10a. State 10b. County		10c City	/. Town or Lo	cation				10	d. Inside City Limits
	sho sho	5			1	ooklyr						1 Yes 2 No
	28a-f	ect	MD Anne  10e. Street and Number	Arundel	101	OUKIYI	10f. Zip Code		10	0g. Citizen of Wha	at Count	rv?
	a or	늅	791 Sunnyfiel	d Lane			212	25		U.S.A		,
	ns 23	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in U.	S. 13. V			Specify Yes or No- rto Rican, etc.)	14. Race -		
	r Iten	표	1 ☐ Never Married 2 ☐ Mar	ried Armed F	orces? 2 Z No				rto Rican, etc.)		White, 6	etc.
3	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If VAC (	iive Dates:		1□Yes 2ŽNo	Specify:		Specify:	W	hite
ò	72 ho	Completed	15. Deceder	nt's Education est grade completed	n	(Give	ient's Usual Occup	durina most of wo	orking	16b. Kind of Busin	ess/Ind	ustry
7	thin 19.	npie	Elementary/Secondary (0-12)		(1-4or 5+)	life. L	DO NOT use retired	d) -		Real Est		
7	ygier ygier her th		12	1		Admii	nistrativ		ane (First, Middle, M		Late	
yianu	be fill	Be	17. Father's Name (First, Middle, George Joseph		er				aine Lilli		Z	
2	d Mer narke	2	19a. Informant's Name/Relations			19h Mailin	na Address /Street		Rural Route Number,			Code)
Ma	d 2 si th an 7 is r		Mr. Kurt Yourk		ısband		•		Brooklyn			
ย์	1 an Heal tem 2	1	20a. Method of Disposition	0,110	20b. P	lace of Dispo	sition (Name of	1		20c. Location - Cit		wn, State
2	ages ont of t: If It		1 Burial 2 Cremation 4 Donation 5 Other (5				natory`or other plac Jalley Me		3,2004	l'imonium :	, MD	
aitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show styr injury or other traumatic avant, Ira Medical Examinar must be notified at appear.	H	21. Signature of Funeral Service		. 1				ingleton I			
Ö	Departiment of the second of t		> (Vichallo)	WMOUL P	no1415				.W., Glen			
p.	11-5		23a. Pert1. Enter the disease, o shock, or heart failure. List	r complications that	caused the death	n. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory arre	est,		Approximate Interval Between
	Pnysician		Immediate Cause (Final			TATI (	Bren	et Ca	13/2 1			Onset and Death
	/Medical		disease or condition resulting in death)	d.	o (or as a consequ			31			1	
	Examiner		Conventinity list conditions	b								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consequ	uence of):						
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C		-0					1	
Ď,	cate be executed obysicien and the burial-transit	<u> </u>	1030king in dodin) cast	Due to	o (or as a consequ	uence or):						
00/00	certificate be executed iding physicien and ise as the burial-transit	dicai		d								
OX O	ding p	0	IF FEMALE:	23c. If yes, o	utcome of pregna	incv				23d. Date of	f delive	v
0	wrequires that the death certifical been signed by the attending planould be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Fetal	Ideath 3	Ectopic pregnancy Other (specify) _	1		Month		Day Year
j.	y the	iysi	1 □ Yes 2 28No 9 □ Unknown	9□ Unk			, , , , , , , , , , , , , , , , , , , ,					
ř.	requires that the leen signed by th hould be detache	by Pt	Part II. Dther significant conditi	ions contributing to	death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribu	ite to th	e cause of death?
200	quires n sign								1 □ Ye	s 200 No 3[	Proba	ibly 4 DUnknown
ecords	law rec as bee 2 shot	iete							24a. Was ar	24b. Wei	re autop	sy findings available
I	0 - 0	Completed							autops perform	ned? dea	th?	pletion of cause of
N (a)	ician: Th certificate rector, pag	0	25. Was case referred to medica	al le				26. Place of De	eath (Check only one	7-1-1		<i>A</i>
		To B	examiner? 1 □ Yes 2 ☒ No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursing	Home 5 Reside	nce 6 Other	Specify.	)
0	ng Ph ter th		27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date (Mo	e of Injury onth, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe ho	w injury occurred		
0	endir sath. or: Al	atic	2 Accident invest	tigation			M 1 🗆	Yes 2 □ No				
UIVISION	ler de lirect	ertification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	mined 200. Flat	ce of Injury - At he ding, etc. (Specify	ome, farm, str y)	eet, factory, office		28f. Location (Sti City or Town	reet and Number ( , State)	or Rural	Route Number,
_	urs al	O	no continu Afficiation	n - Physician To N	ha baat of multiple	udadaa daad	a negressed at the time	ma data and alaa	and due to the en	woo(a) and man		atod .
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely tilled in by the funeral di	dicai		ing Physician: To the I Examiner: On the and ma								
	o the	Med	29b. Signature and title of certific				29c. Licens	e number	29	9d. Date signed (A	Aonth, E	Day, Year)
	⊬ ≱ ⊢ ŏ		In it	( win	*,		2) 18	320		11/29/0	+	
	$\sigma_{i}$		30. Name and address of person	n who completed ca	use of death (Item	n 23a) (Type.				1-1/		
	1.		Johnitat			153	FACES	(3)	いかれい	ille m	) 2	1053.
	Sta	ate	31. Date filed (Month, Day, Year		Registrar's Signa	iture	/					
	Registi	rar	DEC 03	2004	merra	13	Sporks	/				

			1 - For State Registrar	State of Maryl		artment of I rtificate of			ene . 12 0 0 4	38353
	Physic /Medi	ical	1. Decedent's Name (First, Middle, L		ZIL	PAICH		2. Date of Death Month	Day Year	
A CONTRACTOR	Exami	*	4a. Facility Name (If not institution, gi	LITAN HO	SPITAL	BAL	or Location of Dea	2 F	4c. County of Dea	th
	Funeral Director			4 CT 11 A CT = 1	yrs. last birthday) 81 Yrs.	Months Days	If Under 24 Hr Hours Mir		9. Bir 22 M	thplace (State or Foreign puntry) laryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-1 show any injury or other treumetic event; I'rs Modical Examiner must be notified at ance.	by Funeral Director	MD Baltin 10e. Street and Number 7400 Old Harfor	nore	Baltimo			10g.	Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
-0036	should be filed within 72 hours after dea of Mental Hygiene. marked other than "neturel", or Items:	ed by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify: W	nite
121215-0036	filed within 72 Hygiene. other than "ne ent, ire Medic	Completed	(Specify only highest gi	ade completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done DO NOT use retire DMEMAKEY	during most of wo	orking	Own Hor	•
Maryland	should be fi ind Mental H s marked ott umetic ever	To Be	John H. Hilinski  John H. Hilinski  19a. Informani's Name/Relationship		10h 14-We	- Add (0)	Veronio		ıski	
	1 and 2 sho Health and 10m 27 is ma		Mary Anne Sulliv	an- Daughter	1803	Wendover	Road Ba	Aural Route Number, Caltimore, M	laryland 2	21234
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		1 X Burial 2 Cremation 3 Command of the Command of the Command of the Command Service Lice	fy) F	Parkwood ain 22	sition (Name of natory or other place Cemeter) Name and Addre	12,	/2/04 Baeonard J. R Baltimore,	Ruck, Inc	Maryland.
	Firysician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the done cause on each line.  a	leath. Do not ente	or the mode of dyin	ng, such as cardia	c or respiratory arrest,	riary rank	Approximate Interval Between Onset and Death
8760, <	the death certificate be executed  y the attending physician and iched for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PHZDX Due to (or as a const c. PL2HE Due to (or as a const d. LUNG/	/SMA( sequence of): (M/F)2 sequence of):	DEM	ENT	BRILLAT A	IDN	
.O. Box 6	at the death certific by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date of deli	very Day Year
ecords, P.	The law requires that ite has been signed b page 2 should be deta	by	Part II. Other significant conditions (	contributing to death but not	resulting in the un	derlying cause give	en in Part I.	23e. Did tobacc		the cause of death?
		Completed						24a. Was an autopsy performed 1 Yes 2 2	prior to c death?	topsy findings available ompletion of cause of
of	Attending Physician: Th r death. sctor: After this certificate by the funeral director, pag	Certification; To Be	25. Was case referred to medical examinar?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation  3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Year,	EP/Outpatient 28b. Time of Injury	28c. Injury Work	<sup>9r:</sup> 4 □ Nursing H	ath (Check only one)  tome 5 Residence  28d. Describe how in		ify)
5	Dir.	al Certifi	4 Homicide determined	building, etc. (Spe	ecify)			28f. Location (Street City or Town, Sta	ate)	Ī
	To the Hospitel within 24 hours a To the Funeral completely filled	Medica	(Check only 2 Medical Examone)	ysicien: To the best of my k niner: On the basis of exam and manner stated.	knowledge, death ination and/or inve	estigation, in my op	pinion, death occu	irred at the time, date a	and place, and due	to the cause(s)
)	Wii P T 0		29b. Signature and title of certifier  30. Name and address of person who	mD Completed cause of deeth (III	tom 22a) /Time 5		5000	NOV.	EMBER,	29,2004
	Sta	to.	DR.UTKLI LIYSA  31. Date filed (Month, Day, Year)	Completed cause of death (If Completed Cause	MARITA	N HOSPIN	TAL 56	OI LOCH 2	AVEN BU	LUD, BALTIMOL
4	Sta Registra		DEC 032	004 Dener	as by	Asa v	61			

Physician /Medical Examiner

the Maryland

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed after death 24 hours a within 24

Division of Vital Records, P.O. Box 68760,

Complications of	Acute and Chronic Alco	noi Aduse	1 ☐ Yes 2 ☐	]No 3 Probably 4 Nunknov
			24a. Was an autopsy performed?  1 Yes 2 No	24b. Were autopsy findings availat prior to completion of cause o death? 1 ☑Yes 2☐No
25. Was case referred to medical examiner?		26. Place of Dea	ith (Check only one)	
1XX es 2 □ No	Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3	□ DOA Other: 4 □ Nursing H	lome 5 Residence 6	□ Other (Specify)
27. Magner of Death  1 Anatural 5 Pending 2 Accident Investigation		28c. Injury at Work?	28d. Describe how injury	
3 Suicide 6 Could not be determined		actory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier (Check only one)  1 Certifying Pl 2 Medical Exam	nysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place pation, in my opinion, death occu	, and due to the cause(s) rred at the time, date and	and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifier	Ellan md	29c. License number OCME		e signed (Month, Day, Year) MBER 26, 2004

State Registrar

Medical

31. Date filed (Month, Day, Year) DEC 0 3 2004 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



111 PENN STREET, BALTIMORE, MARYLAND 21201

the

			For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of H tificate of I	iealth and Death	d Mental Hy	/giene () ()	4 38355
	Physici	an	1. Decedent's Name (First, Middle, Las.	)				2. Date of De		3. Time of Death
	/Media	cal	4a. Fecility Name (If not institution, give	Charles L. At	kinsor	1 4b. City, Town, or	L section of On	Novem		2004   10:50 A <sup>M</sup>
194	Examir	ier	3128 Gracefield R	·		Silver		ratu i		tgomery
	Funeral		Social Security Number     6. Se	x 7. Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, Da	rth ay, Year)	Birthplace (State or Foreign Country)
L	Director		217 18 6165 Usual Residence of Oecedent	82	115.			June (	6, 1922	Maryland
	arylan ahow	ř	10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	the N 28e-f	Director	MD Montgome  10e. Street and Number	ery Si	lver S	oring 10f. Zip Code			10g. Citizen of W	1 Yes 2 No
	23a or		3128 Gracefield Ro	oad Apt. 204		20904			-	l States
920	d within 72 hours after death with the Maryland Jene. r then "natural", or Itema 23a or 28e-f ahow the Medical Exeminat must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1943—	If	Vas Decedent of Hi Yes, specify Cuba □ Yes 2⊠ No	ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	o- 14. Race	- American Indian, k, White, etc.
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	ent's Usual Occupa	ation	vorkina	16b. Kind of Bu	
21215-0036	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Super	kind of work done of OO NOT use retired	)	, or king	Cag s E	lectric Co.
	be filed with tal Hygiene. d other ther event, the M	BeC	17. Father's Name (First, Middle, Last)		Dupci	VISOI	18. Mother's N	ame (First, Middle		
Maryland	should be ind Menta inmerked umetic av	To	Frederick Atkinson					ia Loving		
Mai	end 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (T) Ruth M. Atkinson/V							State, Zip Code) 20904 pring, MD
ore,	- 7 2 5		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 □F	20b. PI	ace of Dispos	sition (Name of atory or other place	9)	Date		City or Town, State
Baltimore,	T T P		*4 □Donation 5 □ Other (Specify)	Cre	st Law	n Mem. Ga	ard. 11-			tsville, MD
Ba	permit. Departm Imports any inju		21. Signature of Funeral Service Licens	- outle	41	12 Old Co	olumbia	Pike Ell	icott Ci	Family FH Inc. ty, MD 21043
	Pnysician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.						Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ		Larrino	1845 6 22 )	1199 V	mi tas to	iti 10 months
	Examiner	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	manage offi	bine.				
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	bue to (or as a consequ	erice or).					
, 00	icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	ence of):					
68760,	ificate be executed g physician and as the burial-transit	edlcal		1						
Вох	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 □t	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
œ.	s that t ned by e detac	by Ph	Part II. Other significant conditions cor				n in Part I.	23e. Did to	obacco use contrit	oute to the cause of death?
Sud	w require been sig should b	ted b	Chrisis yamp	hocyfic 21	opsw	34		101	Yes 2□No 3	Probably 4 Unknown
Division of Vital Records, P.O.	rsician: The law r s certificate has be lirector, page 2 sh	Completed	Animia, Em	Physima	HIAS	ufinsi:	<u>~</u>		rmed? pri	ere autopsy findings available for to completion of cause of ath?  Yes 2 No
<u>X</u>	ding Physician: The I h. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner?	lospital:		Othe		eath (Check only o	nne)	
0	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury	R/Outpatient 28b. Time of	3 DOA 28c. Injury Work	4 Nursing	Home \$ Resid	dence 6 Other	(Specify)
Sior	tendin Jeath. tor: Aft the fun	atlo	1 Natural 5 Pending investigation	(Month, Day Year)	Injury		? es 2 ☐ No			
DIX	or the Hospital or Attending Physicien: within 24 hours after death as a fire death To the Funerel Director; After this certifica completely filled in by the funeral director;	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Tow	vn, State)	or Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel completely filled	edical	29a. Certifier Certifying Physical Check only one) 2 Medical Examile	sician: To the best of my know ner: On the basis of examination and manner stated.	rledge, death on and/or inve	occurred at the time estigation, in my opi	e, date and place inion, death occ	e, and due to the curred at the time, o	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	To the within To the compl		29b. Signature and title of certifier	· / A		29c, License	number		29d. Date sign <i>e</i> d (	(Month, Day, Year)
			> Con 74. M	12			573		11-16-	cci
N 1	1		//							
10	~		30. Name and address of person who co	age a	23a) (Туре, Р - <del>XX</del> С	rint) Pature	+ Par	Kwan 1	Jumba.	- MO RICLY

Director    Part	38356
Funeral Director  4a. Fecility Name (If not institution, give street and number)  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  When the property of Death  127-46-9939  127-46-993	3. Time of Death
Director  217-46-9939  132M 2 F 58  Yrs. Months Days Hours Min. Sept. 6, 1946  Mary  Usual Residence of Decedent	
0	place (State or Foreign intry) Tand
11519 Hoof Beat Trail  20657  United State  11 Marital Status  12 Was Decedent Ever in U.S. Amed Forcass? 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  17. Father's Name (First, Middle, Last)  Richard L. Anderson  19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig  Lillian Anderson / Wife  P. O. Box 2089 Lusby Maryland 20657	10d. Inside City Limits 1 ☐ Yes 2 No
Specify: While the state of the	can Indian,
County Gove    County Gove   C	
Richard L. Anderson  Porothy Smeigh  Richard L. Anderson  Do ro thy Smeigh  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig  Lillian Anderson / Wife  P.O. Box 2089 Lusby Maryland 20657	ernment
Lillian Anderson / Wife  P.O. Box 2089 Lusby Maryland 20657	o Code)
20a. Method of Disposition    20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or To cemetery, crematory or other place)   20c. Location - City or To cemetery, crematory or other place)   20c. Location - City or To cemetery, crematory or other place)   20c. Location - City or To cemetery, crematory or other place)   20c. Location - City or To cemetery, crematory or other place)   20c. Location - City or To cemetery, crematory or other place)   20c. Location - City or To cemetery, crematory or other place)   20c. Location - City or To cemetery, crematory or other place)	own, State
200. Dox 2009 Lusby Maryland 20057  201. Method of Disposition   200. Location - City or To commetery, crematory or other place)  202. Name and Address of Facility   203. Place of Date   204. Location - City or To commetery, crematory or other place)  203. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	al Home, Inc.
The life of the sease of complications that cause and and each. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)   PULMONARY EMBOLIS	Approximate Interval Between Onset and Death  2 WEEKS
Sequentially list conditions, b. MULTIPLE ORGAN PAILURE:  Due to (or as a consequence of):	3 WERT
Tarly leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  CORUNTRY ARTERY DISEASE  Due to (or as a consequence of):  CORUNTRY ARTERY DISEASE	3 WEEKS.
IF FEMALE: 23d. Date of delivery   23d. Date of deli	ery Day Year
S S S S S S S S S S S S S S S S S S S	
	psy findings available mpletion of cause of
25. Was case referred to medical examiner?  1	r)
27. Manner of Death   Shatural   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   28e. Place of Injury At home, farm, street, factory, office   28f. Location (Street and Number or Rura City or Town, State)   28e. Place of Injury At home, farm, street, factory, office   28f. Location (Street and Number or Rura City or Town, State)   28e. Place of Injury At home, farm, street, factory, office   28f. Location (Street and Number or Rura City or Town, State)   28e. Place of Injury At home, farm, street, factory, office   28f. Location (Street and Number or Rura City or Town, State)   28e. Place of Injury At home, farm, street, factory, office   28f. Location (Street and Number or Rura City or Town, State)   28f. Location (S	
The state of the s	the cause(s)
Abon Hayanga RES · 000 NoVEMBER 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2004.
State Registrar  AWORI HAYANGA GOO H. WOLFE STREET BALTIMURE MARYLAND 21227  31. Date filed (Month, Day, Year) NOV 1 6 2004  32. Egistrar's Signature	

State of Maryland / Department of Health and Mental Hygiene

			Decedent's Name (	First, Middle, La			•		te of L		2. Date of De	Reg. No. 2	004	
	Physicia		lva	F		В	urkett				Nov 25,	2004	Year	5:55am
	/Medic Examin		4e Fecility Neme (If n				uncu		4	b. City, Town, or	Locetion of Death		nty of Deeth	J.558111
			Cumberla	nd Nursi	ng Home	)			Çı	umberlai	nd	Alleg	gany	
	Funeral Director		5. Social Security Nun  234-38-95  Usual Residence of D	595	ex 7. □ M 2√xF	Age (In yrs.	lest birthday) Yrs.		er 1 Year Days	If Under 24 Hr Hours Mir		1927		place (State or Foreign otry)
P C a	M 1	Ī		0b. County		10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limits
Ma	28a-f sho	후	MD	Allegai	ıy		Cuml	oerla	nd					1 □ <b>X</b> es 2 □ No
th th	or 28a-f	Fe	10e. Street end Numb	er				10f. Z	ip Code			10g. Citizen o	f What Cour	ntry?
ŧ	23	<u>e</u>	135 N. Me	echanic S	Street				2	21502			JSA	
5-0020 72 hours after death with the Mandard	al', or items	Ē	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>3 ☐ Widowed 4 [</li></ul>		12. Was Decede Armed Force 1 Test Yes 2 If Yes, Give Year or Date	es? →No			edent of Hisecify Cubar	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Ri Bi	ace - Americ lack, White, hify: white	etc.
ה ה	"natural",	bet	/Specify	5. Decedent's Ed only highest gre	ucation		16e. Deced	lent's Usi	ual Occupe	tion	orkina	16b. Kind of	Business/Ind	dustry
N 4	- 66	Completed by	Elementary/Second	ery (0-12)	College (1-4	or 5+)		DO NOT	use retired)	uring most of wo	rking			_
אַ הַ	tygie rt t	8	12				Clerk					G.C. M		Co.
ב ב ב	and Mental Hygiena.  In marked other than "  Cumatic event, its We	Ď	17. Father's Neme (Fin								me (First, Middle,		im <i>e)</i>	
L A	d Me mark	P	Glenn 7		Supp. Brintl		10h Mailia	- A -l-l	(0)		(Hofe) T			
e, Ma	Health and am 27 is mu ther traum	-	Vincent B	urkett		sband	135	N. M	lecha	nic Stree		erland	[	MD 21502
Saitimore, Maryiand 21215-0020 emit. Pages 1 and 2 should be filed within 22 hours at	Department of Health and Mental Hygiens important: If item 27 is merked other than any injury or other traumatic event, the MDGs.	_	1 🔀 urial 2 🗆 0 4 🗆 Donetion 5	Cremation 3 ☐ ☐ Other (Specify	)		Place of Dispo- cemetery, cren stlawn M	emor	ial Gar	dens	Date 11/29/200			MD
Bait	Depar impor any in		21. Signature of Fune	ral Service Licen	Del	in	. 22	Name a S 10	nd Address Carpelli 08 Virg	i Funeral I inia Aveni	Home, P.A. ue; Cumbei	land, MI	D 21502	2
E	hysician /Medical xaminer		23a. Part1. Enter the shock or heart fa Immediate Cause (Fin disease or condition resulting in death)		a	7	or as a conseq	M/2	ZM	TIA				Interval Between Onset and Death
The law requires that tha death certificate be executed	nding physician and use as the bunal-transit	Medic	Sequentially list condition of eny, leading to imme cause. Enter Underly Cause (Disease or injustrational that initiated events resulting in death) Las	· L	b		r as a consequ							
death C	attar d for u	<u> </u>	Oct II Other elevities	nt conditions on		- h4 4	delegate de la secono						1	
that tha	igned by the attandi ba datached for use	by Physician/	Part II. Other significan		14R01			denying	cause give	n in Part I.	23 B. Did to			the cause of death?
Physician: The law requires to	has been sig ge 2 should b	Completed									24a. Was a perfor		ava	re autopsy findings illable prior to npletion of cause leeth?
	page	5									1 🗆 Y	s 2 No	10	Yes 20 No
clan:	actor	Be :	25. Was cese referred examiner?	-							ath (Check only or	10)		
Physician:	S E	2 2	1 Yes 2 No 27. Manner of Death		Hospital: 1 ☐ Inpa 28a. Date of I	njury	ER/Outpatient 28b. Time of	-	OA Other 28c. Injury : Work?	44 Nursing F	lome 5 Reside			)
Attanding	ath. : After e funer	100	1 ☐ Naturel 5	Pending investigation	(Month,	Day Year)	Injury	М		es 2□No		, , , , , , , , , , , , , , , , , , , ,	1.75	
5	s after death.	Certification:		Could not be determined		Injury - At ho etc. (Specif)	ome, farm, stre	et, factor	y, office		28f. Location (Si City or Town	reet and Num n, Stete)	ber or Rural	Route Number,
a Hospital	Funer Funer taly fil		29a. Certifier 1F (Check only 2 one)	Certifying Phy Medical Exami	sician: To the bearing on the basis and manner	or examinat	wiedge, death ion end/or inve	occurred estigation	at the time	, date end place nion, death occu	e, and due to the coursed at the time, d	ause(s) and mate and place,	anner as sta , and due to	ated. the cause(s)
To the	within 2 To the compla		29b. Signature and title	of certifier	1	2-		29	c. License	number	2	9d. Date sign	ed (Month, D	Day, Yeer)
				m	KI	1			D	0054004	1	11/	27/	7
-	1	3	0. Name end eddress	of person who d	mpleted cause o	deeth (Item	23e) (Type, F	rint)						
	2		Shiv Kha	inna M.I	)		1221	F N	ationa	al Hiahw	ay LaVale	MD 2	1502	
	State Registra	<b>5</b>	1. Date filed (Month	C 63 20	32. Regi	strar's Signa	ture		<i>p</i> -			=		

DHMH 16 Rev 6/95

		1 - For State of Maryland / Departm Certific	ent of Health and late of Death	Mental Hygier	2004	38358
Physicia /Medic		Decedent's Name (First, Middle, Last)     ROSE BLUBAUGH			)ay Year 2 04	3. Time of Death /4/128 M
Examine Funeral	er	Sacred Heart Hospital C 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If UI	City, Town, or Location of Deat City Der Can der i Year If Under 24 Hrs ths Days Hours Min.	nd Brate of Birth	O Bid	th  thplace (State or Foreign  buntry)
Director		Usual Residence of Decedent	Tis Days Hours Will.	JAN 2 192	8 MAR	RYLAND
ne Maryla 8a-f shov	ctor	MARYLAND ALLEGANY FROSTBURG				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
3a or 2	E D	10e. Street and Number 12609 VALE SUMMIT ROAD, SW	. Zip Code 21532	10g. C	Citizen of What Co	ountry?
-0036 hours after death with the Maryland tural; or Items 23a or 28a-f show at Examinet must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 22 ☐ No	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puert s 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify:	
1215- within 72 ane. than "nar	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  HOMEM	f work done during most of wor T use retired)	rking	Kind of Business	/Industry
0 5 9 5 0	To Be C	17. Father's Name (First, Middle, Last) GEORGE W. SKIDMORE	18. Mother's Nar EDNA DUC	me (First, Middle, Maide		
es 1 and of Heal		JOHN BLUBAUGH, SON 12740 V  20a. Method of Disposition    XBurial 2   Cremation 3   Removal from State   20b. Place of Disposition cometary, crematory	or other place)	AD, SW, FRO	STBURG, Location - City or	MD 21532 Town, State MD
Baltimore, permit. Pages 1 ar Depertment of Hea Important: If Item 2 any injury or other		. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	CEMETERY 11/2  and Address of Facility  S FUNERAL HOME	60	W. MAIN	FROSTBURG ST. MD 21532
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	mode of dying, such as cardiac IS Phythnu	4		Approximate Interval Between Onset and Death  Unt Ermun
376(	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				
death death of for a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal death 3 Ectop 4 Pregnant at time of death 5 Other	c pregnancy (specify)		23d. Date of deli Month	ivery Day Year
S the se	2	Part II. Other significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing to death but not resulting in the underlying the significant conditions contributing the significant conditions conditions contributing the significant conditions contributed the significant conditions contributed the significant conditions conditions contributed the significant conditions con	ng cause given in Part I.	23e. Did tobacco		the cause of death?
has has	Completed	Diaketes Mellitus		24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
/Ita	Se l	25. Was case referred to medical examiner?		th (Check only one)	lo 1 Tes	2 No
on of ding Phys After this funeral di	ertification; 10	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 1  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  1 Inpatient 2 ER/Outpatient 3 1  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M	28c. Injury at Work?  1 Yes 2 No	lome 5 Residence 28d. Describe how inj		cify)
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	ر د	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	tory, office	28f. Location (Street a City or Town, Sta		iral Route Number,
To the Hospital Within 24 hours of To the Funeral of Completely filled	edicai	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occur check only one)  1 ☐ Medicel Examiner: On the basis of examination and/or investiga and manner stated.	tion, in my opinion, death occu	rred at the time, date ar	nd place, and due	to the cause(s)
To th Withir Comp	Me	29b. Signature and title of certifier  Scharcem	29c. License number  D 256 3	8 NO	ate signed (Month	h, Day, Year)  242004
٥		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SATURNINA CHANGM 2 10701N Dut	29c. License number D 25 6 3 y Hearge, Creen	KS.W FROZI	busha	nefar \$21532
Stat Registra	e	31. Date filed (Month Day, Year) 2004 32. Degistrar's Signature	books		,	,

			1 - For State Registrar	State of Maryland		artment o		and Me	Reg	ne	) () [ <sub>4</sub>	383	59
	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day October 16 2								Year	3. Time of	
	/Medi	cal	Bessie Myrtle		October				16	2004	10:20	) P <sup>M</sup>	
	Examir Funeral	ner	4a. Facility Name (If not institution, give street and number)  25955 Quinton Road			4b. City, Town, or Location of Death  Mardela Springs				4c. County of Death Wicomico			
			5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Y	ear If Under		B. Date of Birth (Month, Day, Ye				or Foreign
	Director	Н	216-16-7372	<sup>™ 2</sup> <b>X</b> F 80	Yrs.	Months Da	ays Hours	Min.	(Month, Day, Yellay 17	1924	Mary	lace (State o rtry) Land	3
	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Int: If item 27 is marked other than "natural", or Items 23s or 28s-f show inty or other traumatic event, the Medical Exercit with an Item national at	ō	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	um or Lo	antin -							
											'	0d. Inside Ci	
		Directo	Maryland Wicomi  10e. Street and Number	.co Ma	raeı	La Spr			100	Citizon	of What Cour		
		0	25955 Quinton R	beo.			837			J.S.		itiy:	
		Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. V			gin? (Speci		14. R	ace - Americ		
9		Ē	1 Never Married 2 Married		Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:					Black, White, etc.  Specify: Black			
8		d by	3 Widowed 4 □ Divorced										
15		Completed	15. Decedent's Education (Specify only highest grade completed)  [Secondary (0.12)] [Seco										
12		дшс	Elementary/Secondary (0-12)	College (1-4or 5+)		nestic				Non			
p		To Be C	17. Father's Name (First, Middle, Last)	<u> </u>	DOI	iicbc10		er's Name (i	First, Middle, Mai				
lar									Hopkins				
Maryland 21215-0036			19a. Informant's Name/Relationship (Typ	pe, Print)	9b. Mailin	g Address (Str	reet and Numbe	er or Rural F	Route Number, C	ity or Tow	m, State, Zip	Code)	
			Angela Scott (Da		5748			nLoo	p Marde	ela	Md.21	837	
Baltimore,			20a. Method of Disposition  1    Burial 2 □ Cremation 3 □ Re	emoval from State ceme	tery, crem	sition (Name of natory or other	place)	Dat	122/	. Location	n - City or To	wn, State	
tim	ortmen ortant: injury		`4 □ Donation 5 □ Other (Specify)				m Gard	en /	104 F		on,Md	•	
Bal	permit. Pages Dependent of the Important: If ite any injury or of other		21. Signature of Funeral Service License  ### ### ### ### ####################	tewart	<sup>2</sup> S	tewar 21 Wes	t Fune st Rd.	ral Sali	Home sbury,M	id.2	1801		
П	Americal Examiner  The burial-transit		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										ween
		i d	Immediate Cause (Final disease or condition resulting in death)  a. adenocarcinoma of intestine months										
				Due to (or as a consequence	e of):	, ,							
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. OIHUSE mestas total C disease   Due to (or as a consequence of).							conths	Fi		
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
ó	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequenc	e of):								
8760,	ite be iysicia ie bui	Ical	d										
9		Med	IF FEMALE:										
Вох	death certific e attending p id for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea	Ectopic pregnancy				23d. Date of delivery				
P.O.	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 🗌	Other (specify	)		<del></del>	l N	Month	Day Y	'ear
	res that the death certification of the attending be detached for use as	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the								a cause of de	eath?	
of Vital Records,	law requires that the as been signed by th 2 should be detache	d by	Hx of Breast CA						1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown				
00	w require been sli should b	Completed											
Re	The lay								24a. Was an autopsy performed		prior to con death?	ipletion of ca	use of
tal	an: T tificat tor, pa	a)	25. Was case referred to medical				26 Place	of Dooth /	performed	No	1 🗆 Yes	2 No	
<u> </u>	Attending Physician: The Is reasth. sctor: After this certificate ha. by the funeral director, page 2	To B	examiner?										
0	ng Ph ter th neral	nc:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending (Month, Day Year) 1 Natural 1 Pending (Month, Day Year)										
<u>S</u>	eath. or: Ai	Certification;	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No										
Division	or Att	Ē	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Hospital 24 hours a Funeral E												
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To t To t		29b. Signature and title of certifier			29c. Lice	ense number				ed (Month, D	lay, Year)	
			1/6	XW			4156	7	10	/19/	04		
£			30. Name and address of person who con	pleted cause of death (Item 23a	(Type, P	Print)	, al-	1.5	01001				
		to	Nicholas Dudas	145 E. Carro 32. Registrar's Signature	011 8	ot 501	15Dury	MD	21801				
	Sta Registr		OCT 2 0 200	4 Serera	G	Span	ks						

State of Maryland / Department of Health and Mental Hygiene Reg. No. UU 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Nov. 14, 2004 Rose Batwinis 8:45a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Renaissance Gardens Silver Spring 9. Birthplace (State or Foreign Country) Penna. If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours Min 1 M 2 X 89 Director 183-36-1230 8/02/1915 Usual Residence of Decede the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Montgomery Rockville Director 1 ☐ Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ŏ 11611 Hiching Post Lane 20852 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 20No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 White 3 Widowed 4 Divorced Specify: "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) Coilege (1-4or 5+) 5+School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Blanchetti Catherine Ponsetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Isn any injury or other traun Robert Batwinis/Son 11611 Hiching Post Lane Rockville, Md 20852 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 0 Donation 5 ☐ Other (Specify) Fayette City, Penna. 11/18/04 Mt.Auburn Cem. 21. Signature of Fuheral Service Licens e PHILIP<sup>Addos</sup> RINALDI FUNERAL SERVICE, P.A. Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ord na glars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, i.d. y, leading to minorial cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ysician and e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 by Physician/Medicai the attending physiched for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown δ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ № 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 Yes 2 1 No 1 Yes 2 LANG To the Hospital or Attending Phyaician: "within 24 hours after death." To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one. Other: 4 Dwarsing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: s after dea... 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 59524 NOV 2004 mumang iD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOVEEN J. PUTHUMANA, 3110 GRACEFIELD ROAD, SILVER SPRING 31. Date filed (Month NO) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Mary E. Bartholome 4:10 <sup>p м</sup> November 14, 2004 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Spring Silver Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 TXF Yrs. 216-44-2821 Director 81 Sept. 19, 1923 Pennsylvania Usual Residence of Decedent the Maryland 10a State 10b. County show 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or Items 23a or 28a-f show the Westeal Examinar must be notified at Directo 1 ☐ Yes 2 No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12202 Gaynor Road 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. other than "naturel', or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White \$ Specify: 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Government other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be t Department of Health and Mental I Importent; If item 27 Is marked of Bernard Aloysius Burke Genevieve Catherine Barrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire Vukovich/Niece 25954 Kiley Court, Murrieta, CA 92563 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of November 17 20c. Location - City or Town, State Gate of Heaven 1 Burial 2 Cremation 3 Removal from State injury of \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Cemetery Silver Spring, Maryland 21. Signature of Puneral Service Licenses any in Francis Address Collins Funeral Home Inc atle 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Interstitial Pneumonitis disease or condition resulting in death) Month /Medical Due to (or as a consequence of) **Examiner** Alveolar Pneumonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 1 Month Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by Recent Right Hemicolectomy for Colon Carcinoma 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No of Vital 1 Tes 2**X** No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 XNo 1 Minpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1X Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funerel I filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D02338 (auejua November 17, 2004 numua 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard P. Delaney, 3929 Ferrara Drive, Silver Spring, MD 20906 M.D.

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

NOV 17

2004

32. Registrar's Signature

			1 - For State Registrar	State of Ma	ryland /		rtment <i>tificate</i>			and M	ental Hy	giene	200	t.	201	ን ፖ ለ
	·		Decedent's Name (First, Middle, Last)								2. Date of De	ath	<del>. U U</del>	<del></del>	3. The 1	Death-
	Physici /Medi		FRANCES LOUISE BOWM	AN BUTLER	<b>?</b>						NOVEMB	ER 1	5, 200	<b>0</b> 4	5:30	) Р м
	Examir		4a. Facility Name (If not institution, give st. CIVISTA MEDICAL CEN				4b. City, T	own, or <b>PLA</b>		f Death	-	4c.	CHAR			
	Funeral		5. Social Security Number 6. Sex		(In yrs. last b	oirthday)	If Under 1	Year	If Under 2	24 Hrs.	8. Date of Bir (Month, Da	th	9		lace (State	or Foreian
	Director		217 44 0030	<sup>M 2</sup> <b>X</b> F 5	i9	Yrs.	Months	Days	Hours	Min.	SEPTEMBE	Ř 12,	1945		YLAND	
	show		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation							11	0d. Inside (	City Limits
	e Mary la-f sh liffed	ctor	MARYLAND CHARLES		PC	OMFRI	ET								1 X Yes	s 2□No
	with the Mi a or 28a-f. Le notifie	Director	10e. Street and Number 8320 WARREN DRIVE				10f. Zip (	ode 0675				-	izen of Wha			
	er death w Items 23a	Funeral		2. Was Decedent Ev	ver in U.S.	13. V				in? (Spe	cify Yes or No Rican, etc.)		14. Race -			
980	the P	by Fur	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:			Yes, specif		Specify:	, Puerto I	Rićan, etc.)		Specify:	White, 6		
21215-0036	72 hours "natural",	eted	15. Decedent's Educa (Specify only highest grade	ation completed)	16	(Give	ent's Usual kind of work	done di	ırina most	of working	na	16b. K	ind of Busin			
121	within ene. than "	Completed	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or 5+		life. D	OO NOT use HEALTH	retired)				ш	EALTH	TNT	пістр	7
	Hygie other	Be Co	17. Father's Name (First, Middle, Last)		110	MII I	ILALII	7			(First, Middle			TIAT	OSIKI	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ira M	To B	CHARLES HENRY BOWMA  19a. Informant's Name/Relationship (Typo		10	h Mailin	m Address /	Chronic			ISE JOI				0.41	
	はまなさ		DANIEL BUTLER / HUS								FRET, I			206		
Baltimore,	ges 1 and it of Health If item 27 or other tr	100	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place cemet	of Dispos	sition (Name natory or oth	of er place	) 1	D	ate	20c. Lo	ocation - Cit	y or To	wn, State	
ij	Pages tment of tant: If it		* 4 □ Donation 5 □ Other (Specify)		ST. JO				1		ER 19,20	04	POMFRE	Г, М	ARYLANI	)
Bal	permit. Pages Department of Important: If i any injury or once.		21. Signature of Fundral Service (Constant)	INSON MOOSE	33	TH	Name and ORNION 30 LTV	FUNE	RAL HO	ME, P	.A. IDIAN HEA	D. MA	ARYLAND	20	640	
10			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the cause on each line	he death. Do	not ente	r the mode	of dying	, such as o	cardiac or	r respiratory a	rrest,	DISEASE OF S		Approxima Interval Be Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Hypec	415	00									Oriset and	Death
ı	Examiner			Due to (or as a	consequence	e of):										
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	e of):	1 -	1								
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	than	CV	bes	tero									
8760,	te be execute ysician and e burial-tran:		L.	Due to (of as a	consequence	e or):										
9	g phys as the	edical	d.													
Вох	leath certific attending p	an/M	230. Was decedent pregnant	c. If yes, outcome of 1 ☐ Live birth 2		th 3□	Ectopic pred	nancv					23d. Date of		*	
O. E	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at tii 9☐ Unknown			Other (spec						Month	ľ	Day	Year
<b>Q</b>	res that the igned by be detact		Part II. Other significant conditions contri	ibuting to death but	not resulting	in the un	derlying cau	ise giver	in Part I.		23e. Did to	obacco u	se contribu	te to the	e cause of	death?
Vital Records,	v requires been sign should be	ed by									101	res 2[	□No 3[	] Proba	ably 4 🗌	Unknown
eco	law re las be	ompleted									24a. Was		24b. Wer	e autop	sy findings	available
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Ĭ.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	spital:				Other	*		(Check only o					
of	Physical dispersion of the second dispersion o	-	1 Yes 2 PNo 27. Manger of Death	28a. Date of Injury		Time of		. Injury	at at		8d. Describe I			Specify)	)	
ion	death. ctor: After y the funer	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	М	Work?	os 2□N	i						
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, f (Specify)	farm, stre	et, factory,	office		2	8f. Location (\$ City or Tox	Street and vn, State,	d Number o	r Rural	Route Nun	nber,
	ppital cours a ceral I		29a. Certifier	cian: To the best of	my knowledo	ge, death	occurred at	the time	, date and	I place, a	nd due to the	cause(s)	and manne	er as sta	ated.	
	To the Hos within 24 h To the Fun completely	edical	(Check only 2 Medical Exemine one)	r: On the basis of e and manner state	xamination a	nd/or inv	estigation, in	my opi	nion, death	h occurre	d at the time,	date and	place, and	due to	the cause(s	5)
	To the within 2	Σ	29b. Signature and title of certifier	1 4. HA	2		29c.	License	nedmun			29d. Date	e signed (N	fonth, D	lay, Year)	
0			20 Name and office of	1 1000	\\	. CT		20	1)	2		1//	17/0	4		
1	27		30. Name and address of person who com KRISHAN M. MATHUR.					ROAT	. WAT	.DORE	, MARY	T.AND	2060	וס פו	IIT <b>T</b> T	102
	Sta	ite	31. Date filed (Month, Day, Year)	32. Roostrar	's Signature		/		, 1111	UILL	, initi	1111		ان ب	نالم ا	102
	Registr	ar	NOV 1 7 20	14 1 13000	a A	1	man s									

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			for State Registrar	State	of Maryla			nt of H <i>te of L</i>		Menta	l Hygier	211111	383	63
	Dharaiai	t è	1. Decedent's Name (First, Midd							2. Date	of Death		3. Time of	
	Physici /Medio		John Alan Bar	rett						Nov	ember	16, 2004	5:40	P M
	Examir	er	4a. Facility Name (If not institution		number)		1		Location of Dea	ath		4c. County of Death		
			323 McCauley  5. Social Security Number	6. Sex	7. Age (in vrs	s. last birthday)	I	nowin	If Under 24 Hr	S. 8 Date	of Birth	Cecil	place (State o	- Foreign
	Funeral Director		212-78-5071	1 <b>X</b> M 2□ F		42 Yrs.	Months		Hours Mir	n. (Moi	nth, Day, Yea	4.1962	olace (State ontry)  MD	or Foreign
			Usual Residence of Decedent 10a. State 10b. Count		100.0	in Town and		1			0001 2			
	ith the Marylan or 28a-f show se notified at	ŏ				City, Town or Lo							10d. Inside C	ity Limits
	28a-f	rect	MD Ce.	cil		Conowin	-	ip Code	<del></del>		100.6	Citizen of What Cou		
	3a or	Funeral Director	323 McCauley R	oad			1,5,,,,	2191	e			ISA	in y i	
	death	nera	11. Marital Status	12. Was D	ecedent Ever in Forces?		Was Dece	edent of Hi	spanic Origin? (	Specify Yes	or No-	14. Race - Ameri		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health ard Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23s or 28s-1 show other treumatic event, the Medical Examinar must be natified at	by Fu	1 Never Married 2 Ma	rried 1 TYe	s 2 No Give		ii Yes, spa 1 □ Yes		Specify:	erto Hican, e	tc.)	Black, White,		
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212	filed within Hygiene.	Com	12	College	9 (1-401 5+)	Wel	der					Railroad		
nd	2 should be filed within and Mental Hygiene. 18 marked other then eumatic event, the M	Be	17. Father's Name (First, Middle						18. Mother's Na	ame (First, I	Middle, Maid	en Sumame)		
Maryland	should be ind Mental I	2	Earl A. Barret			181111						pincott		
Ma	d 2 sho th and t7 is mu treum		19a. Informant's Name/Relation Thomas L. Barro						nd Number or F Oad, Co			y or Town, State, Zip	Code)	
	ges 1 and of Health If item 27 or other tr		20a. Method of Disposition	2007 SUN	20b.	Place of Dispo cemetery, crer	sition (Na	me of		19-200		21918 Location - City or To	own, State	
E	0 0		1 ☐ Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (		iii State				Home,			sing Sun,	MD	
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service	Licensee	1	22	2. Name a	nd Addres	s of Facility R	.T. F	pard F	uneral Ho	me. P.	Α.
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Е			23a. Parti. Enter the disease, of shook, or heart failure. Lis										Approximate Interval Bett Onset and I	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Dro	whing c	emplic	ating	au	ite sub	arach	noid he	emorrhage	Onset and t	76au1
	Examiner .		, , , , , , , , , , , , , , , , , , , ,	Due	to (or as a conse	quence of):	O	600	Λ 11 10 14			emirchage		
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	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b>										
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68760,	icate be executed physician and s the burial-transit	edlcal		d										
			IF FEMALE:	23c. If yes, (	outcome of pregr	nancy						22d Date of delive		
Вох	death a atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live	e birth 2 Fet egnant at time of	al déath 3 🗆	Ectopic p Other (s					23d. Date of delive Month	-	/ear
P.0	at the de by the a tached	hys	9 Unknown	9 Un	known									
	gned gned be de	ру Р	Part II. Other significant condit	ions contributing to	death but not re	sulting in the u	nderlying	cause give	n in Part I.	23e		use contribute to th		
ord	w require	eted									1 🗌 Yes	2 No 3 □ Prob	ably 4 □U	Inknown
of Vital Records,	e law has b	Completed								24a	. Was an autopsy	24b. Were auto	psy findings a npletion of ca	
a		e Co	05.14								performed? Yes 2□ N		2 No	
Ž	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 XYes 2 No	Hospital:	Inpatient 2	] ER/Outpatien	t 3 🗆 D		26. Place of De			6 <b>X</b> Other (Specify		-
	ding Phy I. After thi funeral c	Η.	27. Manner of Death	28a. Da	te of Injury onth, Day Year)	28b. Time of Injury		28c. Injury Work	at	28d. Des	cribe how inj	ury occurred	) at s	cene
ior		atlo	2 94 7 100100111	igation 11-11	6-04	4:50	РМ	1 🗆 Y	es 2 No	subje	et d	Irowned		
Division		Certification	3 Suicide 6 Could 4 Homicide deter	nined 286. Pla	ce of Injury - At hilding, etc. (Spec	nome, farm, stri	eet, factor	y, office		28f. Loca City	tion (Street a or Town, Sta	and Number or Rura te) 323 MC	Route Numi	ber.
	To the Hospitel or within 24 hours after To the Funerel Directory completely filled in b		20a Cartifice 1 Cartiful	na Physician To	the heat of my lea	A.	t he			icono	winge	mo		1 PCU
	e Hospitel 124 hours a e Funerel l letely filled	edical	29a. Certifier 1 ☐ Certifyi (Check only 2 ☐ Medice one)	Exeminer: On the	basis of examination basis of examinations.	ation and/or inv	occurred estigation	at the time in, in my opi	e, date and plac inion, death occ	e, and due turred at the	time, date a	s) and manner as st nd place, and due to	ated. the cause(s)	)
	To the within 2 To the complet	Me	29b. Signature and title of certific	ər			29	c. License	number		29d. D	ate signed (Month, i	Day, Year)	
		highi. m. J O.C.M.							O.C.M.E.		Nov	rember 17,	2004	
	5		30. Name and address of person	_	use of death (Ite									
1			LING LI	mid	Designed Of			Stree	et, Balt	imore	, Mary	yland 2120	)1	
	Sta Registr		NOV 1 9 200	4 Kenny	Registrar's Sign	Soule	,							

		•	For State 1 - State Registrar	of Maryland		artment of Hertificate of D		Mental Hygi	iene 2001	38364
ì	Physici	an	Decedent's Name (First, Middle, Last)  John Thomas Brewer					2. Date of Death Month	Day Yea	D M
>	/Medic Examin		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or	Location of De	November ath	14, 200 4c. County of De	3,12
	ZAGITIII		975 Juliet Lane				Arnol		Anne Ar	
	Funeral Director		5. Social Security Number 6. Sex 217–46–3437	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi			Birthplace (State or Foreign Country) Maryland
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County  Maryland Anne Arundel		, Town or Lo	cation Arnold				10d. Inside City Limits 1 ☐ Yes 2\\ \text{Cx}\text{No}
	th the	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	ath wi	ral	975 Juliet Lane			1	21012		U.S.A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or iteme 23a or 28a-f show say injury or other treumetic event, I're Medical Examinational be neithed at ODGe.	Completed by Funeral Director	1 Never Married 2 Married 1 7 Yes.	ecedent Ever in U.S Forces? es 2000 Give or Dates:	1	Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2[★]No		(Specify Yes or No- erto Rican, etc.)	Black, W	merican Indian, hite, etc. Vhite
21215-0036	vithin 72 ho ne. hen "netur e Medical	mpleted		e (1-4or 5+)	(Give life. L	lent's Usual Occupation of work done du DO NOT use retired)	iring most of w	rorking	6b. Kind of Busines	
and 5	d be filed v ental Hygie cad other ti c event, In	To Be Col	17. Father's Name (First, Middle, Last)  Thomas Brice Brewer,		_Advei	ctising ar	18. Mother's N	eting ame (First, Middle, M erine Tate		oloyed
Maryland	nd 2 shoul Ith and Me 27 is mark	ř	19a. Informant's Name/Relationship (Type, Print)  Janis P. Brewer/wife					Rural Route Number,		
Baltimore,	ages 1 ar ant of Hea it: if item? y or other		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal fro  1 □ Donation 5 □ Other (Specify)	om State Ce	emetery, cren	sition (Name of natory or other place			Oc. Location - City	or Town, State
Baltir	permit. F Departme Importer any injur		21. Signature of Funeral Service Licagsee	1,2	22	. Name and Address	of Facility Jo	ohn M. Tay	lor Funer	
8760,	death certificate be executed e attending physician and Exam d for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	n each line.	cremence of):	ti C (			J.,	Approximate Interval Between Onset and Death The Local Control Control The Local Con
P.O. Box 68	death certific e attending p id for use as	Physician/Medical	in the past 12 months?	outcome of pregnar re birth 2  Fetal egnant at time of de known	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
	Se 70 9	by	Part II. Other significant conditions contributing to	o death but not resu	Iting in the ur	nderlying cause giver	n in Part I.			to the cause of death?  Probably 4 Unknown
Division of Vital Records,	The ate h page	Completed						24a. Was an autopsy perform 1 \( \text{Yes} \) 2	ed prior to	
Ĕ	Physicien: Th this certificate ral director, pag	) Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1	□Inputiont 2□5	ER/Outpatien	Othor		eath (Check only one		
on of	ding Phys h. After this funeral di	tlon; To	27. Manner of Death 28a. Da		28b. Time of Injury	28c. Injury : Work?	at Nursing	Home 5 Z Resider  28d. Describe how		неспу)
Divisi	al or Attending safter death. I Director: After d in by the fune	Certification;	3 Suicide 6 Could not be	ace of Injury - At hor idling, etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or a State)	Rural Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medicel Examiner: On the and m	the best of my know e basis of examinati anner stated.	vledge, death ion and/or inv	occurred at the time restigation, in my opi	n, date and place nion, death occ	ce, and due to the car curred at the time, dat	use(s) and manner e and place, and di	as stated. ue to the cause(s)
	To the vithing To the comp	M	29b. Signature and title of gertifier	n .		29c. License	number	7 1	d. Date signed (Mo	nth, Day, Year)
			1/40/	WW		1000	>150	/ //	ovem be	n 15,2004
			30. Name and address of person who completed c	MD 90	23a) (Type, 1	Print) 51991R	RJ	Ja7e 30	D An	15,2004 napolis,40 2(401
	Sta Registr		NOV 1 6 2004	2. Agistrar's Signati	K A	book				

State of Maryland / Department of Health and Mental Hygier () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day November 28,2004 **Physician** 3:10 A M J R CALDWELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nonths | Days | Hours | Min. | Dec 2, 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2□ F 83 Director 449-20-4827 Texas Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f ehow must be notified at Texas Hale Plainview Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 SW 8th Street 79072 U.S.A. r than "natural", or Items the Medical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or llen any injury or other freumatic event, the Medical Evantinat once. 1 XYes 2 □ No 1942 If Yes, Give
Year or Dates: 1946 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White þ 3 Widowed 4 Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Caldwell Samuel Daniel Lizzie May Faith ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Beth A. Caldwell/Wife 116 SW 8th Street, Plainview, Texas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Plainview Cemetery Nov 30,2004 Plainview, Texas 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home

106 East Church St, Frederick, Maryland 21701 21. Signatu of Funeral Service Gensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician espirator Ci. /Medical Due to (or as a consequence of): Examiner 11 elim oni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has page 2 autopsy performed? 1 Yes 2- No of or Attending Physicien: after death. Director: After this certifica funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 hrpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 14 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) D006087 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle Tan, M.D., 400 West Seventh Street, Frederick, Maryland 21701-4506 31. Date filed (Month 32. Registrar's Signature State 2004 Registrar

			For State Registrar	State o	f Marylan		artmen rtificat					giene Reg. Né	004	38366
	- 6		Decedent's Name (First, Middle, I	ast)							2. Date of Dea	uth Day	Vand	3. Time of Death
	Physicia		Pauline 6	ordy	Caus	ev							Yeer 2004	1:45 P M
	/Medic Examin	***	4a. Facility Name (If not institution, g				4b. City,	Town, or	Location of	of Death		4c. C	County of Deeth	
	Lxaiiiii		St. Mary's Nur	sing Cer	nter		Le	eonar	dtow	n		St	. Mary'	S
	Funeral			. Sex	7. Age (In yrs.		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h v. Year)	9. Birthp	lace (State or Foreign
	Director		212-01-8899	1□M 2X0F	87	Yrs.	I.O. I.O.				March 6,	1917	Mary	lánd
	2 .		Usuel Residence of Decedent  10a, State 10b, County	<u></u>	10c Cit	y, Town or Lo	ocation						1	0d. Inside City Limits
	aryla shov	2												1 XYes 2 ☐ No
	M 98-1	ecto	Maryland St. Ma	ry's	Le	onardt	101. Zip	Code				10a Citiza	en of What Cour	ntry?
	with the	급	10e. Street and Number	O-web.	1122A		101. 21		550			. og. ome	USA	,.
	death with the Maryland ms 23a or 28a-f show rmust be nutified at	Funeral Director	26680 Cedar Lane		edent Ever in U.	S. 13.	Was Dece			igin? (Spe	ecify Yes or No-	14	4. Race - Americ	an Indian,
	item item	Ľ,	1 Never Married 2 Married	Armed F	orces?		If Yes, spe	city Cuba			ecify Yes or No- Rican, etc.)		Black, White,	etc.
Ş	irs af	by	3  Widowed 4 □ Divorced	If Yes, G Year or I	ve		1 🗆 Yes	<b>2</b> € No	Specify:			5	Specify: W	nite
ž	72 hours after neturel', or its dicel Exemine	ted	15. Decedent's			16a. Dece	dent's Usua	al Occupa	ation	t of work	ina	16b. Kin	d of Business/Inc	dustry
ת מ	within 7; ene. than "n	ple	(Specify only highest Elementary/Secondary (0-12)		1-4or 5+)	life.	kind of wo DO NOT u	se retired	)	O HOIK	9			
<u>'</u>	d with giene.	Completed	12			Nurs	ing A	ssis					pital	
2	al Hy al Hy l othe	Be (	17. Father's Name (First, Middle, La	ist)					18. Mothe	er's Name	e (First, Middle,	Maiden S		
0	Ment Ment arked	ပ္	Larry Rando		Gordy				Mani	_	Bell		Shock	
a L	d 2 should be filed within 72 hours after death with the Marylan th end Mental Hygiene.  7 is marked at Hygiene.  7 is marked at the than "naturel; or items 23s or 28s-1 show the unartic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship	(Type, Print)	. =		_						Town, State, Zip	Code) 22427
e, E	and sealth m 27			(daughte		P. O			, BOW		Green,		gillia Z	
OLE	H ite		20a. Method of Disposition 1   Burial 2 □ Cremation 3	Removal from	State	emetery, cre	matory or o	ther plac					Ĺ	
E	permit Pages 1 and Deparment of Health Important; If Item 27 eny injury or other t	1	'4 □Donation 5 □ Other (Spe		Wic									Maryland
g	ermit lepa npo ny in		21 lignature of Funeral Service Li	censee	e) mm	2	Hollo	way	Funer	al H	Ome Pro	fess	ional As	ssociation and 21804
	00500		23a. Pert 1. Enter the disease, or co	Lachung									, Maryla	Approximate
			Shock, or neart failure. List of	nly one cause on	each lime.	n. Do not en	A	E OI CIVILI	= //	a diac (	al respiratory ar	1031,		Interval Between Onet and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	K214	WAL	oru	116	21/10	01/2	4			hm.
	/Medical Examiner		A Cooking in Cooking	Due to	(or as a consider	uence of):	11.1		Dis	, 0	holona	1	71	hal
		<u>.</u>	Sequentially list conditions,	b. Due to	(or a conseq	uence of).	1434	10/1	Ma	1	ngaro	MIN	7-	IVA
	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury		Non	MA	11/14	+ NL	ONI	1	)b			421
	be executed sicien and burial-transit	xar	that initiated events resulting in death) Last	C. Due to	(or as a conseq	uence of):	9	170-	1	4			7	7
976	death certificate be executed e attending physicien and of for use as the burial-transit	dical		d					1					J
89	flicate p physics as the											T	1	
ROX	eath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant		atcome of pregna		□Ectopic p	reanan cu	,			2:	3d. Date of delive	,
ň	death e atte d for	cla	in the past 12 months?	4☐Preg	nant at time of c		Other (s)						Month	Day Year
O.		hys	9 Unknown	9□ Unk	nown			_						
S,	The law requires that the tie has been signed by thoage 2 should be detache	by P	Part II. Other significant condition	s contributing to	death but not res	ulting in the	underlying (	cause giv	en in Part	l.				he cause of death?
ğ	w require been si should b										10,	res 2 🗖	No 3 Prot	pably 4 Unknown
000	aw re	Completed									24a. Was	SV	24b. Were auto	psy findings available mpletion of cause of
Ĕ	The law	E									perfo	rmed? 2 2 No	death? 1 ☐ Yes	2□ No
Vital Records,	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						26. Plac	e of Deat	h (Check only o	ne)		
>	Physician: r this certific ral director,	70	1 ☐ Yes 2 ๋ No	Hospital: 1	Inpatient 2	ER/Outpatie	ent 3 D	OA Oth	er: 4 🔁 N	ursing Ho	ome 5 Resid	dence 6	Other (Specif	ý)
0	tending Physician: leath. tor: After this certific the funeral director,		27. Manner of Death  1  Natural 5 Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury		28c. Injun Wor	k?		28d. Describe I	now injury	occurred	
Division of	endii eath. or: A he fu	Certification:	2 Accident investiga	ation of he			М		Yes 2	No	-0(1)	0	111 -1	- L Charles Abarahan
ž	or Attendated of the Director:	Ě	3 Suicide 6 Could no 4 Homicide determin	200. Flat	e of Injury - At h ding, etc. <i>(Speci</i>	ome, farm, s fy)	treet, factor	y, office			City or Tox			al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer			<b>D</b>			46	1 - 1 - 1		and referen	and done to the	new=-(-)	and manager	tatad
	Hospitel 24 hours a Funeral stely filled	edical	(Check only 2 Medical E	Physician: To the xaminer: On the	basis of examina	owledge, dea ation and/or i	ith occurred nvestigation	at the tir n, in my o	ne, date a pinion, de	nd place, ath occur	and due to the red at the time,	date and	and manner as s place, and due to	the cause(s)
	To the P within 2 To the P	Med	one) 29b. Signature and title of certifier	and ma	ner stated.		29	c. Licens	e number			29d. Date	signed (Month,	Day, Year)
	To Wild		250. Signature and title or optime	U	21/2	$\mathcal{A}(\mathcal{N})$		T	0/	419	9			
	10		an	WENT 1	NVO C	201 (7	Drint\	1	00	UV	1	NOT	vember l	.5, 2004
	mg		30. Name and address of person w					otch	Rd.	Ho11	.vwood	Marv <sup>°</sup>	land 206	36
	·	tate	31. Date filed (Month, Day, Year)		Registrar's Sign		4	1	Ks		J J,			
	31	Telle	NOV 1	6 2004	Mener	- /	_/ _	14104	RN					

		1	For State Registrar	State of Marylar	•	artment of rtificate o			giene () (	04 38367
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath Day	3. Time of Death
	Physici: /Medic	_	James Lev	in Cart	wrigh	t Sr.		Octobe	er 18,2	2004 10:30 <sup>€</sup>
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town	, or Location of Do	eath	4c. County	
			32250 Shavox R			Salis	-4			omico
14. o	Funeral Director		212-40-9448	9x 7. Age (In yrs. ⊠M 2□F 61	. last birthday) Yrs.	Months Day	ar If Under 24 h	Hrs. 8. Date of Birt Month, Day 3 / 18 /	1943	9. Birthplace (State or Foreign Country) Maryland
	and	-	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	f eho	ō	Maryland Wicc	omico	Salis	hurv				1 ☐ Yes 2 🔯 No
	the 28s	Directo	10e. Street and Number	111111111111111111111111111111111111111	DUITE	10f. Zip Code	9		10g. Citizen of V	What Country?
	h with	D I	32250 Shavox	Rd.		218	04		USA	A
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or liems 23a or 28a-f ehow event, the Medical Examinat must be molified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in C Armed Forces? 1X Yes 2 No If Yes, Give Ar Year or Dates:Viet	-msz	Was Decedent of If Yes, specify Co 1 ☐ Yes 2 ☑ N		? (Specify Yes or No- uerto Rican, etc.)	14. Rac Blac Specify	e - American Indian, ck, White, etc. y: white
Ş	2 hou		15. Decedent's Ed	ucation	16a, Dece	dent's Usual Occ	cupation	alria a	16b. Kind of Bu	usiness/Industry
21215-0036	nin 72	pie	(Specify only highest gra-	de completed) College (1-4or 5+)	life.	DO NOT use reti		working		
2	should be filed withir and Mental Hygiene. marked other than imatic event, the M	Completed	12	2	Po	lice C				Enforcement
Maryland	be filed ital Hygie of other	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,		16)
<u>X</u>	should tind Ment	၉	James Lester Ca					Marie La		
<u>la</u>	2 sh and is m		19a. Informant's Name/Relationship (7					r Rural Route Numbe		
	1 and Health em 27 ther to		Katherine Cart  20a. Method of Disposition	20h	Place of Dispo	250 Shapsition (Name of	avox Ro	L. Salisk	20c. Location	1D 21804 City or Town, State
ŏ	Pages nent of h ant; if its ury or of		1 Burial 2 Cremation 3	Removal from State	remetery fred	o Memo	rial 1			sbury, MD
Baltimore,	it. Pa rtmer rtant njury		*4 □ Donation 5 □ Other (Specify 21_Signature of Funeral Service Licen		the second second					
Ba	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke eny injury or other traumatic 2008.		21 Signature of Pulleral Service Electric	meson CFS	S P   "	HOTIOW	ay Fune	eral Home	Profe	essional Assoc
			23a. Part1. Enter the disease, or comp			ter the mode of o	tying, such as car	diac or respiratory ar	rest,	MD 21804 Approximate
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	quence of):	ocarde.	ed Ling	arction		Interval Between Onset and Death
*	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conss	queries of):					
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	icate be executed physicien and s the burial-transit	Exa	resulting in death) Last	Due to (or as a conse	quence of):					
8760,	ite be iysicie of bu	cal		. d						
9	ng ph	Med	fF FEMALE:							
P.O. Box	es that the death certificate be executed igned by the attending physicien and be detached for use as the buriat-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. ff yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregna □ Other (specify)			1	nte of delivery onth Day Year
	The law requires that the ate has been signed by the page 2 should be detache	þ	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	inderlying cause	given in Part I.			tribute to the cause of death?
00.	v require been sig	etec						24a. Was	24h	Were autopsy findings available
al Records,	ician: The law certificate has rector, page 2 a	Completed						autop perio 1 Yes	osy rmed? 2 No	prior to completion of cause of death? 1 Yes 2 No
Vital	Physician: this certific ral director,	Be c	25. Was case referred to medical examiner?  1 Tyes 2 No	Hospitaf. 1 ☐ Inpatient 2 ☐	TER/Outpatio	nt 3 DOA	Other	Death (Check only o		nes (Canata)
of	Physic this stal dis	.: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	30 DOX 1	njury at Vork?		now injury occur	
ion	Attending I r death. ector: After by the funer	to	1 Natural 5 Pending 2 Accident investigation		Injury		Vork? ☐Yes 2☐No			
Division	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not by 4 Homicide determined	28e. Place of fnjury - At l building, etc. (Spec		reet, factory, offic	се	28f. Location (S City or Tox		ber or Rural Route Number,
	Hospit     24 hour     Funereletely fille	dical (	29a. Certifier Certifying Ph (Chack only one)	ysician: To the best of my kr niner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	th occurred at the ovestigation, in m	e time, date and p ly opinion, death o	lace, and due to the occurred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
	within To th compl	Me	29b. Signature and title of certifier	0			ense number		. 1	d (Month, Day, Year)
)			> Tellfudde	h		Di	29/05	-	10/2	6/04
1	6		30. Name and oddress of person who	completed cause of death (Ite					/	
1	7			Huddleston		3 Milf	ord St.	,Salisbu	ry,MD	21804
	St: Regist	ate rar	31. Date filed (Month, Day, Year)  OCT 2 0 2	32. Registrar's Sign	nature &	Spa	K			

DHMH 17 Rev 1/2001

			ricasc	State of Maryland				-	_	•
			1 - For State Registrar	Otato of Marylan		rtificate of			1. No. 2 11 11	1 20200
			Decedent's Name (First, Middle, Lateral	ist)				2. Date of Death		3. Time of Death
	Physici /Medio		Fremont George C	lark				Month November	Day Year 12, 200	D M
	Examir		4a. Facility Name (If not institution, gir	re street and number)		4b. City, Town, o	or Location of Death		4c. County of De	eath
			Fox Chase Rehab	. & Nursing Cer	nter	1	er Spring		Montgo	
	Funeral Director		507-07-9436	Sex 7. Age (In yrs. I		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y July 2, ]	(ear) 9. E 1919 Ne	Birthplace (State or Foreign Country) ebraska
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	, Town or Lo	ocation				10d. Inside City Limits
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or itams 23a or 28a-f show ther than "natural", or itams 23a or 28a-f show ont, the Medical Examinar counts by mailfied at	ō			Q - 1					1 Tyes 2 XNo
	28a	Director	Maryland Monto  10e. Street and Number	omery	Silver	Spring 10f. Zip Code		100	g. Citizen of What	Country?
	3a o		3554 Chiswick (	Court, Building	36F	20906			USA	
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		Was Decedent of h	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race - Ai Black, W	merican Indian,
9	or its	正	1 Never Married 2 Married	1X Yes 2 No		1 ☐ Yes 2X No			Specify: Wh	
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates: 1941		dent's Usual Occur	nation	1 14	Sb. Kind of Busine	co/ladustar
<u>5</u>	n 72	jete	15. Decedent's E (Specify only highest gi	rade completed)	(Give		during most of won	king	D. KING OF BUSING	symoustry
7	withi iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Elec	tronics	Technicia	n I	Vational	Defense
b	illed Hyg other	BeC	17. Father's Name (First, Middle, Las	t)	,		18. Mother's Nam	ne (First, Middle, Ma	aiden Sumame)	
<u>la</u>	uid be Aenta rked tic ev	To B	Glen Gordon Cla	ırk			Mae Ma	ry Sedlac	ek	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itams 23a or 28a-f show majoury or other traumatic event, the Madical Examination and be mailified at once.		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number, (	City or Town, State	a, Zip Code) 20906
Σ,	is 1 and 2 of Health a item 27 is other trau		LaRita V. Clark/				k Ct.,_B1	dg. 36F.		
ore	M ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 (	G	emetery, cre	osition (Name of matory or other pla of Heaven	Nove	mber 17	c. Location - City	or lown, State
Ë	tant:		* 4 ☐ Donation 5 ☐ Other (Spec	ify)	Cemet	ery	20		-	ing, Maryland
Baltimore,	ermit Separ mpor mpor iny In		21. Signature of Funeral Service Lice	insee (Ann II)	Fr	2. Name and Addre	Collins	Funeral H	Home inc	- MD 00001
	402.44		23a Part Enter the disease or our	nolications that caused the death						ng, MD 20901 Approximate
			23a. Patri. Enter the disease, or our shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	50 1101 011	tor the mode of dy.			-1	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence		Failure				6 Months
r	Examiner				derice ory.					
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequ	uence of):					
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	C						
760,	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
876	ate b	dicai		d						
x 68	that the death certificate of by the attending physidetached for use as the the the the the the the the the the	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	incv				22d Data of	deliner
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta	Ideath 3[	☐Ectopic pregnanc☐Other (specify)	:y		23d. Date of a Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	Juli 31	_ Culer (Specify) _				
Δ.	requires that the seen signed by th hould be detache	y P	Part II. Other significant conditions	contributing to death but not res	ulting in the u	underlying cause gi	ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ds	n signe	d by	Primary Pulmonar	y Hypertension	, Deme	ntia,		1 🗌 Yes	2 🗆 No 3 🗆	Probably 4 XUnknown
Records,	> 1 (0	Completed	Atrial Fibrillat	ion				24a. Was an	24b. Were	autopsy findings available
Re	o _ o	mo						autopsy performe	ed? death	to completion of cause of ? es 2 \sum No
Vital	ician: Th certificate ector, pag	O	25. Was case referred to medical				26. Place of Dea	th (Check only one)		
<u> </u>	d S	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1   Inpatient 2	ER/Outpatie	nt 3□ DOA Ot	her: 4 🔀 Nursing H	ome 5 Residen	ce 6 Other (S	pecify)
n of			27. Manner of Death 1    1    Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe how	injury occurred	
Sio	Attending F r death. ector: After by the funera	catio	2 Accident investigati 3 Suicide 6 Could not	bo -			]Yes 2□No	20/ 1 1/ (0)		
Division	l or Attendafter death Director: In by the	Certification:	4 Homicide determine		ome, farm, si y)	reet, factory, office		City or Town,		Rural Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Sectifying F	Physician: To the best of my kno	wladna dos	th occurred at the t	ime date and place	and due to the con-	ise(s) and manner	as stated
	24 hc Funi	edicai	(Check only one) Medical Ext	nysician: To the best of my kno miner: On the basis of examina and manner stated.	tion and/or in	nvestigation, in my	opinion, death occu	rred at the time, dat	e and place, and o	due to the cause(s)
	To the within 2 To the yomplet	Med	29b. Signature and trips of certifier			29c. Licen	se number	290	d. Date signed (Mo	onth, Day, Year)
)	43		) (Sha			D2	8656		November	15, 2004
	100		30. Name and address of person who							,
			Ravi Passi, M.D.	. 8609 Second	Avenue	#404B,	Silver S	pring, MC	20910	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature /4	Anne Ko				

DHMH 17 Rev 1/2001

			1 - For Stata Registrar	State of	Marylar		artmen <i>rtificat</i>				lental Hyg		00	01	0.0	
	Physici	an	Decedent's Name (First, Middle	_							2. Date of Dea Month	th Da		Year	3. Time o	1 Death
	/Medi	cal	Roberta	L.		Campbe1					Novembe	er 1	4, 2	004	5:35	рм
	Examir	ıer	4a. Facility Name (If not institution 11107 Lombards		Der)				Location			4c.	. County o			
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs.	last birthday)	If Under	1 Year	Spri If Under	24 Hrs.	8. Date of Birth	1	Mont		ace (State of	or Foreign
	Director		226-60-0350	1 □ M 2 1 □ F		60 Yrs.	Months	Days	Hours	Min.	(Month, Day Jan. 6,			Coun	ngton	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation									
	Manyl	tor	Maryland Monto	omerv										'	od. Inside C 1 ☐ Yes	2 □No
	h the	Directo	10e. Street and Number	Jonery	1 51	lver S	10f. Zip	Code			1	l 0g. Citi	izen of Wh	nat Coun		
	23a c	a D	11107 Lombardy	Road			20	0901					USA		•	
	er dea	Funeral	11. Marital Status	12. Was Deced Armed Ford	es?		Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race	America White, 6		
36	rs afte	by F	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 □ Yes 2 If Yes, Give Year or Dat			1 □ Yes 2		Specify:		,,		Specify:			
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23e or 28e-1 show ont, the Medical Evariline must be routified at	ted	15. Decedent	's Education		16a. Deced	dent's Usua	I Occupa	ation			16h Ki	nd of Busi	ness/Ind	uetry	
2	thin 7 e. an "n	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4	lor 5+)	(Give life. l	kind of wor DO NOT us	rk done d se retired,	luring most )	of worki	ng	100.10	110 01 0031	11033/1110	ustry	
2	led wi	Con		5+	,	Nur	sing	Educ	cator			Не	ealth	Car	e	
Maryland	ntal H	Be	17. Father's Name (First, Middle, I	,					18. Mothe	r's Name	(First, Middle, I	Maiden	Surname)			
Ž	should nd Me mark matic	2	James Edward I  19a. Informant's Name/Relationsh			10h Mailin	Addraga	(Street o			. Lenz					
<b>∑</b>	od 2 s lith an 27 is r trau		James R. Campbe		lushand						Route Number					
re,	s 1 ar		20a. Method of Disposition		20b. P	Place of Disposemetery, cren	sition (Nam	ne of		D	Silver		cation - Ci			-1640
Ē	Page nent c		1 ☐ Burial 2 🖾 Cremation `4 ☐ Donation 5 ☐ Other (Sp			tropol Crema	itan	пет ріасе	" No	oveml 200	per 17	\lav	andr		Virgi	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury ocother traumatic event. The Medical Ever the must be rectified at once.		21. Signature of Fyneral Service L	1. /				Addres	s of Facility		Tuneral	Hom	anur.	ra,	v тг.д ті	ша
-	<u>σ</u> Ω ≅ 8 9			Hules		50	0 Uni	vers	Sity H	3 <b>1v</b> d,	W, Sil	Lver	Spr	ing,	MD 20	0901
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cau only one cause on eac	sed the death h line.	n. Do not ente	er the mode	of dying	, such as o	cardiac o	respiratory arre	est,			Approximate Interval Bety	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Anemi											Onset and D	
E	Examiner				as a consequ	uence of): : Uropa	+ h									
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ROX	death certifii e attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnar	ncy	50									-
	death e atte	icla	in the past 12 months?	4□Pregnan	n 2 ☐ Fetal t at time of de		Ectopic pre Other <i>(spe</i>					2.	3d. Date o Month	-		ear
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S.	as the	ρχ	Part II. Other significant condition	s contributing to deat	h but not resu	ılting in the un	derlying ca	use giver	n in Part I.		23e. Did tob	acco us	e contribu	ite to the	cause of de	ath?
Ö	w require been signal	eted									1 Yes	s 2xE	]No 3[	] Probat	oly 4 □U	nknown
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	ding Ph h. After thi funeral	i.i	27. Manner of Death	28a. Date of I		28b. Time of Injury		c. Injury a Work?	at Nurs	ang Hom	e 5% Resider 3d. Describe hov	v injury	occurred	Specify)		
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	l or Atten after deatl Director: I in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin		Injury - At hore etc. (Specify,	me, farm, stre	et, factory,	office		28	If. Location (Stre	eet and State)	Number	r Rural F	Route Numb	ΘΓ,
	pital ours a eral C		29a. Certifier tx Certifying	Dhysisian T. d. b.	-1 -1 1											
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only one)	Physician: To the be kaminer: On the basis and manner	or examinan	vledge, death ion and/or inve	occurred at estigation, in	the time n my opir	, date and nion, death	piace, ar occurred	id due to the cau I at the time, dat	use(s) a te and p	ind manne place, and	r as stat due to th	ed. 1e cause(s)	
	To the within To the compl	-	29b. Signature and title of certifier	-10	10		29c.	License i	number		290	d. Date	signed (N	fonth, Da	y, Year)	
			· VUV	X X	Ale	ini	1	MD208	818						2004	
	20		30. Name and address of person w	ho completed cause of	f death (Item	23a) (Type, P	rint) (Del	Da111	Drof	000	onel Di					
			30. Name and address of person w Margaret Alexa	ander, M.D	. 1160	0 Varnu	ım St.	, N	E, Wa	shin	gton, Do	2g 20	017 P	rovi	dent	Hosp.)
	Stat Registra	е.	31. Date filed (Month, Day, Year) NOV 1 7	32. <del>18</del> 91	strar's Signati	ure 💆	Spa	Kr	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 13:55 PM irainia 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Universit Baltimore 0+ lary If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6 Sax 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1 ☐ M 2 ☐XF 214 71 0635 Director 16 30, Sept 2004 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad othar than "natural", or Itams 23a or 28a-f show othar traumatic evant, the Nedical Examinar must be notified at Be Completed by Funeral Director MD 1 Yes 2 No Howard Fulton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7526 Cherry Tree Drive 20759 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 0 N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roger L. Carter Jennifer Bullinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 I Roger L. Carter/Father 7526 Cherry Tree Drive Fulton, MD 20759 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of I
Important: If it
any injury or o
once. 1 ☐ Burial 2 ☐ Cremation 3 ☑Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 11-19-2004 Lawrence, Kansas 21. Signature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician anoxic prain disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner apnea Sequentially list conditions, if any lasting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Campomelic Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably Be Completed 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature completed cause of death (Item 23a) (Type, Print) 60

DHMH 17 Rev 1/2001

State Registrar egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistrar Reg. No. U U I Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Lesley W. Cooke MAPO: 11 15,04 november /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hunder 1 Year Hunder 24 Hrs. 8. Date of Birth 99. Months Days Hours February 187, 1947 ivista Charles Center medica 7. Age (In yrs. last birthday)
57 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🕱 F Director 148-38-3633 Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Modical Expression out the coulded at 1 ☐ Yes 2 No MD Charles La Plata Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6605 Tip Hill 20646 Drive USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes WNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Athletic Director Public Schools permit. Pages 1 and 2 should be filed. Department of Health and Mental Hermortant: If tem 27 is merany injury or other any injury or other. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Peter S. Welch Lillian Welch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 974 ,La Plata,MD. 20646 Donald E. Cooke/husband 20b. Place of Disposition (Name of commetery, crematory or other place)

Brinsfield-Echols 11/17/04 Charlotte Hall, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee M00945 Co hale 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Interval Between Conset and Death Cons Immediate Cause (Final disease or condition resulting in death) dyschythnig ventrienter **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Lecta Caransma 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of de≱th?
1 ☑ Yes 2 ☐ No 24a. Was an certificate has b autopsy performed? 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Inpatient ည this tor: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No **Director:** 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11-16-04

State

30. Name and address of person who

NOV 1 7 2004

31. Date filed (Month, Day, Year)

B. Larru

completed cause of death (Item 23a) (Type, Print)

mD III

D-33426

LaGrange Ave. LaPlata, MD 20144

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 28, 2004 Frances Decker 9:40pm M Elizabeth November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Buckingham's Choice Health Care Frederick Adamstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Dec 5, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛛 🗶 Dec 132-20-1370 78 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at Frederick Adamstown 1 ☐ Yes 2 XNo Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 Baker Circle 21710 U.S.A. Funerai 14. Race - American Indian, Black, White, etc: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 ts marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) Magazine Publishing Administrative Assistant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Marie Francis Raymond Decker Ann Coppinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 3200 Baker Circle, I-109, Adamstown, MD 21710 Mary Jane Decker/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State permit. Page Department of importent: if any injury or once. Smithsburg Crematory Nov 30,2004 Smithsburg, Maryland \* 4 □Donation 5 □ Other (Specify) MO0706 106 East Church St, Frederick, M 21. Signature of Funeral Service Licensee M00706 106 East Church St, Frederic 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland 21701 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician End Stage Dementia Years /Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Adenocarcinoma of Lung burial-tran The law requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Be Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Failure to thrive; Hypothyroidism; Goit Disorder; 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Restrictive Lung Disease; Immobility Syndrome; autopsy page performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 X No Osteoporosis To the Hospitei or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 XNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident by the 6 □ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after of the Funerei Direct completely filled in b Direc 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D54749 November 29, 2004 30. Name and address of person who completed cause of death (Item 20a) ype, Print) J. Allen Reilly, M.D., 801 Toll House Ave, D-1, Frederick, Maryland 21701-6111 31. Date filed (Month Par Year) 3 2004 32. Registrar's Signature State Locales Registrar DHMH 17 Bey 1/2001

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	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b.	City, Town, o	r Location of			4c. County of	/	
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a Z	shou and N e mer	_	19a. Informant's Name/Relationship (	Type, Print)	19b.	Mailing Ad	dress (Street	and Number	or Rural Route N	umber, City	y or Town, Sta	ite, Zip Cod	de)
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	within 24	Me	29b. Signature and title of certifier	1 mg			29c. License		<u>.</u>	29d. D	ate signed (M	lonth, Day,	Year)
,	(F)		Klen (). Yx				220		1		ovembe	r 15,	2004
	Pgp		30. Name and address of person who	completed cause of death	(Item 23a) (T	ype, Print)	cuti	1= 11	use L	char	- mp	207	06
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State of Maryland / Department of Health and Mental Hygiene Reg. No. 004 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** 5:56 р. м 2004 Nov. 10, Robert Barry Dunigan Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital Betnesua

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Sept. 7, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1☑M 2□F Washington D.C. 80 Director 220-16-8154 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State or than "neturel", or items 23a or 28a-f ehow. Bethesda 1 Yes 2 □ No MD. Montgomery Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7505 Democracy Blvd., #313A 20817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. X Yes 2 ☐ No f Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: ρ 3 Widowed 4 Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Real Estate D.J. Dunigan other Department of Health and Mental High Important: If Item 27 is marked other any Injury or other treumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be fand Mental Hand Mental Hand Mental Hand Mental Hand Mental Hand Mental Hand Mental Helen Marie Whyte David J. Dunigan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7505 Democracy Blvd., #313A, Bethesda, Md. 20817 19a. Informant's Name/Relationship (Type, Print) Patricia Dunigan / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Gate Of Heaven Cem. 11/15/2004 Silver Spring, MD. ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc., 5130 21. Signature of Funeral Service Licensee T Wisc. Ave., N.W., WDC. 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pnuemonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine attending physician and for use as the burial-transit law requires that the death certificate be executed Unknown COPD that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒️ No 24a. Was an rmed? 2 No 1 ☐ Yes Be 25. Was case referred to medical director 26 Place of Death (Check only one) examiner Hospital: 1 XInpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo Certification: To this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D completely filled in Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Menmi D0061631 11-11-04 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20814 8600 Old Georgetown Rd., Bethesda, MD Natasha Chen, M.D. Pay, Year) 17 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene O 38375 For State Registre Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 12, 2<u>0</u>04 NOVEMBER **Physician BETTY** JANE DOLAN. 7:15A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Beltsville 4812 Odell Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🗗 F 217-12-5611 80 Director Dec. 22, 1923 Virginia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits irai', or items 23a or 28a-f show Exemple must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Prince George's Beltsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4812 Odell Road 20705 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify: þ 3 Widowed 4 Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) than College (1-4or 5+) Hygiene. Payroll clerk Greyhound Bus Co. marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filk iment of Health and Mental Hy lant: If item 27 is marked oth lury ocother traumatic event Be Lillian Tester Moulden Wood 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kitty Lou Schneider -Daughter 4806 Garrett Avenue Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o important: If any injury of once. Fort Lincoln Cemetery 11/16/2004 Brentwood, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit death certificate be executed Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 2**X** No Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 this Director: After thi 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Fo the Hospital or Attending 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 24 hours a 1X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 12, 2004 mn 10 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) Hazel Tape, M.D. Kaiser Permanente 12201 Plum Orchard Drive Silver Spring, MD20904

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (M

32. Registrar's Signature

	)	1 - For State Registrar	State of Mary	Cei	tificate of l	Death		Reg. No.	004 3	38376
Physic		1. Decedent's Name (First, Middle Sandra	Divver				Month NOVEMB	Day	Year 2004	3. Time of Death  2:45p  M
/Medi Exami		4a. Facility Name (If not institution	, give street and number)		4b. City, Town, or	r Location of Dea		$\overline{}$	County of Death	2.150
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Funeral Director		5. Social Security Number 578–74–6139	6. Sex 1 M 2 F 7. Age (In	yrs. last birthday) 49 Yrs.	Months Days	Hours Mir		12 <b>,</b> 19	955 Washi	ce (State or Foreign ngton, D.
death with the Maryland ims 23a or 28a-f show rmust be notified at	lor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne A	arundel	City, Town or Lo Laurel	cation				100	d. Inside City Limits
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and 2 shot talth and N 27 Is ma ar trauma		19a. Informant's Name/Relationsh Bernard Divver/			ng Address (Street a					code)
permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic events.		20a. Method of Disposition  1	3 □Removal from State pecify)		coin Ceret		ember19 004	Was	ation - City or Tow hington,	D.C.
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Prysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if am, legiding to immediate cause. Enter Underlying	a Pneun Due to (or as a cor	nsequence of):	rith Con	mp/Ica	+1045			
tificate be executed ng physician and as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a coo	nsequence of):						
oer Idin Ise	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ∰Winknown	23c. If yes, outcome of pr 1 Ulive birth 2 U 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23	d. Date of delivery Month D	ay Year
requires that the death een signed by the atter hould be detached for u	by P	Part II. Other significant condition	ns contributing to death but no	at resulting in the u	nderlying cause give	en in Part I.	23e. Did to		e contribute to the	cause of death?
The lay	Completed						24a. Was autop perfor 1 Yes		prior to comp death?	y findings available pletion of cause of
Physiclan: this certific ral director,	B	25. Was case referred to medical examiner?	Hospital:		t 3CIDOA Othe	0.00	eath (Check only o			
Phy this	5	Yes 2 No 27. Manner of Death	1 Inpatient	2X ER/Outpatien 28b. Time of	1 3 DON	4 🗆 Indianing	Home 5 Resid			
tending Ph leath. tor: After th	ation	1 Natural 5 Pending	g (Month, Day Yea		Work	k? Yes 2 □ No		,,		
To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune.	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi			eet, factory, office		28f. Location (S City or Tow		Number or Rural F	Route Number,
To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	edical C	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the best of my Examiner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	ce, and due to the courred at the time, of	cause(s) a date and p	nd manner as stat lace, and due to th	ed.
0 0 0	45									ne cause(s)

State Registrar ZABICCC AH 31. Date filed (Month, Day, Year) NOV 17 2004

32. Pegistrar's Signature parks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - Stata
Ragistrar\_MFND#17perFH11/17/04,BMW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Mary Elizabeth Doyle /Medical Nov. 8, 2004 5:30 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carriag Hill 5215 Cedar Lane Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month | Day. | Nov • 29 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months 1 □ M 2 □ F 1916 Yrs. Director 213-48-9264 Washington, D.C. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location nartment of Health and Mantal Hygiene. note that it is marked other then "naturel", or items 23a or 28a-f ehov injury gother treumetic event. Its Medical Evantrat must be rottlind at 8. 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5718 Ogden Rd Funeral 20816 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates; 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2☐ No Completed by 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last)
Charles E. Sanford 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles E. Sandford Bertha T. Hermann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Doyle -husband 5718 Ogden Road, Bethesda, MD 20814 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury og once. St. Gabriel's ' 4 ☐ Donation 5 ☐ Other (Specify) Nov.13,2004 Potomac, MD 21. Signature of Europial Service Do 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. N.W., Wash., D.C. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The taw requires that the death certificate be executed Congestive Heart Failure and Due to (or as a consequence of): Box 68760. attending physician by Physician/Medical Dementia IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4☐ Pregnant at time of death Year 5 Other (specify) Division of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 3 ☐ Probably 4 XIUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No performed? 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred 1 🔁 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel hours a To the Funerel 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1031114 D47330 November 9, 2004

State Registrar

NOV 17 2004 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Inomus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

50 W. Edmonston Dr. #207, Rockville, MD Dr. Thomas Joseph, M.D. 32. Pegistrar's Signature souther

20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 9 per fh 8838 12-3-04 vt. Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 1 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov 25, 2004 **Physician** Year Mary О **Emerick** 3:40 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Lions Manor Nursing Home** Allegany Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 4, 1926 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖵 F 78 Yrs 220-16-6365 **Director** Italy Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location sthan "naturel", or items 23a or 28a-f show toe Madical Examiner must be notified at 10d. Inside City Limits MD Allegany Cumberland Director 1 ☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 Seton Drive 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2☐No Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ Specify: white 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Deptriment of Health and Mental Hygiene. Importent: If Item 27 is marked other than "na any mjury or other treumatic event, Ite Madic 2005. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Ballistics Laboratory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Ottieri Elizabeth Fusco Ottieri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Frederick Street MD 21502 Casper Ottieri brother Cumberland 20b. Place of Disposition (Name of cometery, crematory or other place)
Sunset Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/29/2004 Cumberland MD \* 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part / Enter the disease, or complications that caused by deat. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COLORECTAL CANCER Physician METASTATIC 9 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-tran attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) the detached 9 Unknown 9 ☐ Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 1 No 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ZNatural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident the Director: 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOV 29, 2004 D23371 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Qamar Zaman M.D.
31. Date filed (Month, Qay, Year) 625 Kent Avenue Cumberland MD 21502 32. Resetrar's Signature DEC 0 3 2004 State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Mar	yland /	Certifica			wentai Hy	Reg. No.	004	38379
	Physici		1. Decedent's Name (First, Middle, Las MARY BETH		BERC	<u>~</u>			2. Date of D Month	Day	Yeer	3. Time of Death 5:12 A · M
	/Medio Examin		4a. Facility Name (If not institution, give HELLY CEN	street and number)		4b. Ci	ALI	Location of Dea	1	4c. Cou	unty of Death	
	Funeral Director		215-78-1103	TM 2IXIF	in yrs. iast t	Yrs. If Und Month		If Under 24 Hr Hours Mir	1. (Month, D	irth Da <i>y</i> , Yea <i>r)</i> 1968		place (State or Foreign ntry) ryland
	Maryland f show	ior	Usual Residence of Decedent  10a. State 10b. County  Maryland Wico	omico	•	wn or Location	2011					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other than "natural", or items 23a or 28a-f show event, I're Medical Examiner i unt be notified at	al Director	10e. Street and Number 926 Snow Hill		5		Zip Code 21	804		USA		
36	irs after dea il', or Items	by Funeral	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.		cedent of H pecify Cuba 2 X No		Specify Yes or N nto Rican, etc.)		Race - Ameri Black, White, ec <i>ify:</i>	
9500-612	withln 72 hou ene. than "natura ne Modical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)			work done o use retired	ation during most of w	orking		of Business/Ir	dustry
Jana 21	be filed wi ital Hygien id other th event, Ins	Be	17. Father's Name (First, Middle, Last)	0		Disab	led		ame (First, Middle		name)	<u> </u>
Maryla	d 2 should h and Mer 7 is marke traumatic	ဥ	John Engberg  19a. Informant's Name/Relationship (7						Rural Route Numi			
a)	Pages 1 an nent of Heal int: If item 2 iry or other		John Engberg  20a. Method of Disposition  1 XBurial 2 Cremation 3 Characteristics  4 Donation 5 Other (Specify	Removal from State	cemer	nico Me	r otner blac	(8)	Salish Date /16/04			
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Ligen:	uses (FSI)	0	22. Name Holl	oway	ss of Facility Funera	al Home	Prof	essio	nal Assoc
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a BACT	ERI	AL KI	NBU	MONI	4			Approximate Interval Between Onset and Death   MONTH
68/60,	executed BX an and rial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c								
	w requires that the death certifics been signed by the attending ph should be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [ 4 □ Pregnant at tirn 9 □ Unknown	Fetal dea	th 3⊟Ectopic 5  Other (				23d.	Date of delive	ery Day Year
ras, r	quires that in signed b uld be deta	by	Part II. Other significant conditions co	entributing to death but r	not resulting	in the underlying	g cause give	en in Part I.		tobacco use o		he cause of death?
Vitai Records	has has	Completed							24a. Was auto perf 1 Yes	s an 24 opsy ormed? 2 No	b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available mpletion of cause of
VII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	1.		Othe	nr.	eath (Check only			
ō	ding Phys h. After this funeral di	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient  28a. Date of Injury (Month, Day Y	28b	Outpatient 3 Time of Injury M	28c. Injury Work	4 LI Nursing	Home 5 Res	how injury oc		ý) 
5	ospital or Attending hours after death. uneral Director: Aftei iy filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, (Specify)	farm, street, fact	ory, office		28f. Location City or To	(Street and Nu own, State)	ımber or Rura	al Route Number,
	H 42 H 56	Medical (	(Check only 2 Medical Exam	vsician: To the best of r iner: On the basis of ex and manner stated	camination a	and/or investigati	on, in my o	pinion, death occ	e, and due to the curred at the time	, date and place	e, and due to	o the cause(s)
	To the within 3 To the Comple	2	29b. Signature and title of certifier	2-6	200		29c. License		// 0	29d. Date sig		
4	FID		30. Name and address of person who co	completed cause of deat	th (Item 23a	OWHII	DUC LK	20 8	A LISBU	11-1 1R4	ND.	21802
	Sta Registr	_	31. Date filed (Month, Day, Year) NOV 16	32. Registrar's	Signature	19	Spar	Ks/	, - , 5-0-1	,		

Registrar

			1 - For State Registrar	State of I	Maryland /		artment of H				giene 0	04	383	180
	Physici /Medic		1. Decedent's Name (First, Middle Lois Ann	, Last) Wilfand	Eaton					2. Date of De Month		Year 2004	3. Time of	Death
	Examir		4a. Facility Name (If not institution 13446 Rising S		er)		4b. City, Town, or	Location			4c. Count	y of Death		
	Funeral Director		5. Social Security Number 213-50-0267	6. Sex 7. 1 ☐ M 2 🛣 F	Age (In yrs. last bi 44	irthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Nov • 1	y, Year) 3, 1959	9. Birthp Coun Wash	lace (State or try) ington	Foreign D • C
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Mont	gomery	10c. City, Tov	vn or Lo	ocation Germant	town				1	0d. Inside Cit	
	with the 3e or 28a-	Il Director	10e. Street and Number	Sun Lane			10f. Zip Code	20874			10g. Citizen of	What Coun	try?	
5-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "neturel", or Items 23e or 28e-f show aumatic event, the Medical Eventher must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4XX ivorced	12. Was Decede Armed Force	s? XINo		Was Decedent of Hi If Yes, specify Cuba		gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14. Ra	ce - Americ ick, White, o	an Indian,	
21215-0	d within 72 ho giene. rr then "netur the Medical.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education st grade completed)  College (1-4c)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired Contract	during mosi )		ng	16b. Kind of E		,	t
Maryland	9 = 0 \$	To Be C		Vilfand				Lu	cill∈	3	Maiden Sumai Spice	r		
	1 and Health 8m 27 ther tr		19a. Informant's Name/Relationsl  Barbara W. Mar  20a. Method of Disposition		er	13	ng Address (Street a Eagle Ric sition (Name of		1., 5			5512	7	
Baltimore,	permit. Pages Department of I Importent: If it eny injuryer o		1 ☐ Burial 2 🎇 Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature-of, Funeral Service)	pecify)	te cemete	peak	matory or other place ce Cremato Name and Addres	ory   ]	v		Belts	ville		
ñ	Per Dep Imp		23a. Part1. Enter the disease, or shock, or heart failure. List	Complications that cause	ed the death. Do	- F	Rapp Funei 133 Gist A	cal an Ave.,	nd Cr Silv	er Spr	ing, MD	20	910 Approximate	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Brea	as a consequence	of):	_						Interval Betw Onset and Do L Mont	eath
, <sub>0</sub> 0,	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lieuse 1 m luy) that initiated events resulting in death) Last	c	as a consequence									
04/89 X		//Medicai	IF FEMALE:	d	ne of pregnancy								-	
SO. BOX	that the death certiff ed by the attending detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death at time of death		Ectopic pregnancy Other (specify)					te of deliver onth [	y Day Y∈	ar
ecords, r	w requires that the been signed by the should be detache	by	Part II. Other significant conditio	ns contributing to death	but not resulting in	n the ur	nderlying cause give	n in Part I.		23e. Did to	bacco use cont es 2. No		cause of dea	
	The law ate has b page 2 st	Completed								24a. Was a autops perform	ned) (	Were autop: prior to com death? 1 ☐ Yes 2	sy findings av pletion of cau	railable ise of
ion of Vital	Phys this al dii	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investig		jury 28b.	itpatient Time of njury	28c. Injury Work	r: 4 🗆 Nur	sing Hom		e) ence 6 ⊡Oth ow injury occurr			
DIVISION	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of the	niury - At home, fa etc. <i>(Specify)</i>	rm, stre	eet, factory, office		28	8f. Location (St City or Town	reet and Numb n, State)	er or Rural	Route Numbe	₹,
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	Medical	one)	Physician: To the bes xaminer: On the basis and manner s	or examination an	death dor inv	estigation, in my op	inion, deatl	place, ar occurred	d at the time, d	ate and place, a	and due to t	he cause(s)	
	L M L M		29b. Signature and title of certifier	4-6	)		29c. License		80		9d. Date signed			
	Sta	à	30. Name and addless of person v Leon C. Wan 31. Date filed (Month, Day, Year)	o M.D. 1	29/ D.	Curc	Dr. R	ock.	ville	_ MD	20	850		
	Registra	_	NOV 17	2004	wa /	9	sports	/						

			State of Mar	wland / Don	artment of Health and I	Montal Hydian	_	
			1- State Of Mai		artment of Health and I rtificate of Death		2006	38381
			Decedent's Name (First, Middle, Last)		Tancate of Beatif	Reg. N	<del></del>	3. Time of Death
	Physici /Medi		MELVIN L. GATEWOOD			NOVEMBER	ay 26 20	
1	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	<del></del>	c. County of Dea	<del>-</del>
			Union Hospital		Elkton		Cecil	
	Funeral		11X1 M 2□ F	In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year		rthplace (State or Foreign ountry)
	Director	ļ	212-40-8048 Usual Residence of Decedent	62 Yrs.		June 29		Maryland
	yland sow			Oc. City, Town or Lo	ocation			10d. Inside City Limits
	a-f st	ctor	MD Cecil	Elkton				1 X Yes 2 No
	or 28	Funeral Director	10e. Street and Number		10f. Zip Code	10g. C	itizen of What Co	ountry?
	ath w	ra I	408 Graymount Circle		21921	U.	S.A.	
	er de Items	une	11. Marital Status  12. Was Decedent Even Armed Forces?		Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
39	hours after death with the Maryland turel', or Items 23e or 28a-f show al Examinations by Invititied at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No Specify:		Specify:	Black
9	2 hou	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation	16b. I	Kind of Business	/Industry
218	d within 72 hor giene. <b>sr then "netur</b> the Mcdical E	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	life	kind of work done during most of wor DO NOT use retired)	king		,
7	il Hygien other th	Con	10	Dum	np Truck Driver		onstruc	tion
and	be de la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide	•	
Maryland 21215-0036	should ind Mei s mark umatic	2	Franklin Gatewood, Sr.  19a. Informant's Name/Relationship (Type, Print)	106 14-11		Virginia		
<b>∑</b>	N 00 B				ng Address (Street and Number or Ru	-		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John J. Gormley 14, November 2004 4:05 am /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Mariner Health-Circle Manor Kensington Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 11 M 2□ F Months Min. 579-18-0832 83 Yrs. Director Dec. 27, 1920 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show eny injury og other traumatic event; if he Medical Evanines must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐xNo Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 3453 Chiswick Court, #75-1B Funeral 20906 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicon, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □XYes 2 □ No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: 2 lf Yes, Give Yeer or Dates: WWII Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John J. Gormley Nora Barbara Tiernev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Gormley/Wife 3453 Chiswick Court, #75-1B, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition Nov.19 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Crematory 2004 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licensee 500 University Blvd, W, Silver Spring, Md 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical SEPSIS Examiner Due to (or as a consequence of):

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Due to (or as a consequence of): Physiclan/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed the bunial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events. URINARY TRACT INFECTION Division of Vital Records, P.O. Box 68760, resulting in death) Last Due to for as a consequence of Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceusa of deeth? PROSTATE CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Š Completed 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes Yours after death.

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y filled in by the funeral director, pt 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funeral D Medical 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0057/24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9715 Medical Center Dr., #201, Rockville, MD 20850

oaks

32, Registrar's Signature

Registrar

State

Truong Bao, M.D. 31. Date filed (Month, Day, Year)

**NOV 17** 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ROSE S. GAYAN Year **Physician** 5:50 A M NOU 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Morningside House of Friendship Anne Arundel Hanover If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. (Month, Day, Year) March 2, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F 577-34-7628 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Anne Arundel Linthicum 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 748 Andover Road 21090 United States 23a Funeral or Items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by If Yes, Give \*\* Year or Dates: Specify: White 3 X Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) Secretary os 1 and 2 should be filed w of Health and Mental Hygien If item 27 is marked other th Asphalt Institute 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Angelo Stefanelli Cornelia Carbona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan E. Heiser -Daughter 748 Andover Road Linthicum, Maryland 21090 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages 1 ortent: If i 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 11/15/2004 Alexandria, Virginia Importent: \* 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service License 22 Nama and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BLADDER CARCINOMA URINARY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the for use IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending Injury 1 Natural 5 Pending within 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide To the Hospitel 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Misnego D57531 NOV15, 2004 Ms 30. Name and address of pe on who completed cause of death (Item 23a) (Type, Print) Millersville MiD 21102 NEgi 8601 Veterans Muy, 31. Date filed (Month, 32 Registrar's Signature State miles Registrar

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			1. Decedent's Name (First, Middle, Last)  2. Decedent (First, Middle, Last)	1	Certificate of L		2. Date of Death	<del>2004</del>	3. Those subsection
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7	Examir		4a. Facility Name (If not institution, give street and nu	imber)	4b. City, Town, or	Location of Death	4	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex,	7. Age (In yrs. last bird		If Under 24 Hrs.	B. Date of Birth	9. Birtho	place (State or Foreign
	Director		282-14-6829 12M 20F	84	Yrs. Months Days	Hours Min.	(Month, Day, Yea	1920 Ohi	itry)
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	or 28,	Direc	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What Cour	ntry?
	death with the Maryland me 23a or 28a-f ehow rnust be nettilled at	Funeral Director	1714 Lower Millston	e Lane	2180			USA	van ladia
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygjene. Department of Health and Mental Hygjene. Important: If item 27 is marked other than "natural", or iteme 23e or 28e-1 ehow implicators. If item 25e or 28e-1 ehow implicators of the traumatic event, tra Medical Exerciter must be notified at once.	by	Armed For 1 Never Married 2 Married 1 XYes	orces? 2 No ive Dates: Navy	13. Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2🔀 No	spanic Origin? (Speci n, Mexican, Puerto Ri Specify:	ry Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: W	
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	s 1 an f Heali item 2 other		20a. Method of Disposition	20b. Place of	714 Lower Disposition (Name of	Dat		Location - City or To	
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1/2	A		30. Name and address of person who completed cause  1. Date filed (Month, Day, Year)  32. R	se of death (Item 23a) (	Type, Print) 1733	Sali	il,	und 3	180x
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		<b>Funeral Director</b>	11. Marital Status	12. Was Decedent Armed Forces?		B. Was Decedent of Hispa If Yes, specify Cuban, I		Yes or No- n, etc.)	14. Race - Ame Black, Whit	erican Indian,
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	d the death. Do not e	30639 Hamp nter the mode of dying, s	uch as cardiac or res	piratory arrest,	~) Je M	Approximate Interval Between
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			30. Name and address of person Seyed A Jo		death (Item 23a) (Type		shur, m	0 2180	51	
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			For State Registrar	State of Maryl	and / Depa <i>Cei</i>	artment of He	ealth and M Death		pierze O O L	38387
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	e Ma	cto	Maryland Prince	George's A	Adelphi					1 ☐ Yes 2 🔯 No
	or 28	Director	10e. Street and Number			10f. Zip Code			log. Citizen of Wha	t Country?
	ath w	la	1904 Dana Drive	T		20783			U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f ehow early injury or other treumetic event, if a McAlcal Example Train Let notified at ODGe.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 🖫 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1Yes 2 No If Yes, Give Year or Dates:	Į.	Was Decedent of His If Yes, specify Cuban 1 □ Yes 2 No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - , Black, \	American Indian, White, etc. White
8	2 hou	ed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupat	ion		16b. Kind of Busin	
215	hin 72	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give	kind of work done du DO NOT use retired)	ring most of work	ing		,
2	ad wit	Con	12		Homem	aker			Own Hom	e
nd	be fife tal Hy d oth	Be	17. Father's Name (First, Middle, Last,			1	18. Mother's Name	e (First, Middle,	Maiden Sumame)	
<u> </u>	ould Men Parke	ဥ	Dewey Ganzel				Frances			
Mar	12 sh h and 7 Is m treum		19a. Informant's Name/Relationship ( John F. Harding	**		ng Address (Street ar.				
ė,	1 and Healt em 2	and the last	20a, Method of Disposition		b. Place of Dispo	Rolling Rosition (Name of	1		20c. Location - City	
altimore, Maryland 21215-0036	ages ant of it: If it y or o		1 🕅 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Removal from State		matory or other place; shington Cem		1		
ቜ	nit. Partme ortan injur	1	21. Signature of Funeral Service Lices			2. Name and Address				
B	Dep Imp		H Constan	ee Ho		739 Baltin				
Г			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the d	leath. Do not ent	er the mode of dying,	such as cardiac	or respiratory arr	est,	Approximate Interval Between
M	Physician	8 1	Immediate Cause (Final disease or condition	Large Intra	acranial	Bleed				Onset and Death 11/12/2004
	/Medical		resulting in death)	Due to (or as a con	sequence of):	Diccu				11/12/2004
	Examiner		Sequentially list conditions,	b. Subarchnoic						11/12/2004
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a con	sequence of):					
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):					
8760,	icate be executed physician and s the burial-transit	dlcal E		d -						
9	g phy as the	edic							1 - 111	
Вох	leath certific attending p	Physician/Me	JF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	gnancy	Ectopic pregnancy			23d. Date of	,
E	ed for	sicie	in the past 12 months?  1 Yes 2 No	4□Pregnant at time 9□ Unknown		Other (specify)			Month	Day Year
<u>о</u> .	that the de led by the a detached	Phy	9 Unknown				:- O- +1	OCa Didas		te to the cause of death?
Vital Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ò	Part II. Other significant conditions of Atrial Fibrillat		resulting in the u	nderlying cause given	in Pant.			Probably 4 Unknown
ec	has be	Completed						24a. Was a autops	v prior	e autopsy findings available to completion of cause of
E	: The	Con						perform 1 Tes		h? Yes 2□No
ξ	Physicien: r this certificatal director,	Be	25. Was case referred to medical examiner?	Hospital:	_		26. Place of Deatl			
Division of	Phys r this ral dii	. To	1 Yes 2X No 27. Manner of Death	1 X Inpatient 2	2 ER/Outpatien 28b. Time of	nt 3□ DOA Outon	'4 ☐ Nursing Ho at		ence 6 Other (	Specify)
O	th. : Afte	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	r) Injury	Work?	es 2 No		,.,	
N N	Atter	Certification:	3 Suicide 6 Could not b	289. Place of fillury - A	At home, farm, str	eet, factory, office				r Rural Route Number,
ā	s after s after el Dire	Cert	4 _ Homelds	building, etc. (Sp	өспу)			City or Town	i, Siale)	
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, death nination and/or in	occurred at the time vestigation, in my opin	, date and place, nion, death occurr	and due to the cred at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	To the Printing of the Proceedings	M	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (M	onth, Day, Year)
1	(11)		hallhalle	Thomas	2	D0060	443	-	November	15, 2004
2	(10)		30. Name and address of person who	or pleted cause of death (	Item 23a) (Type,					
	-		Nathalie Narciss 31. Date filed (Month, Day, Year)	MD 7600 C	Carroll A	Avenue, Ta	koma Par	k, Mary	land 2091	2
4	Sta Registr		NOV 1 9 2004	32. Registrar's Si	The state of the s					

	an	Decedent's Name (First, Middle, La				2. Date of Death Month	Day Y	3. Time of Dear
/ledic	al	THOMAS  4a. Facility Name (If not institution, give		HERRING	4b. City, Town, or Location of Dea	NOV.	15, 20	004 9:03 A
amin	er				SILVER SPRI		MONTG	
eral		MILLENNIUM HEALT  5-Social Security Number 6. S  578-56-4522	Sex 7. A	Age (In yrs. last birthday		s. 8. Date of Birth	9	. Birthplace (State or For
ctor		579-56-4522	1 <b>X</b> M 2 □ F	61 Yrs.	Months Days Hours Mir	JUNE 13,	1943	N. CAROLINA
_	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Lin
e pai	ō	D.C. NONE			WASHINGTON			1 <b>X</b> Yes 2
edical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code	10	g. Citizen of Wh	at Country?
ag pe		2330 GOOD H	OPE RD.S.	Е.	20020		U.S	.A.
D. I	Funeral	11. Marital Status	12. Was Deceder Armed Forces		. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		American Indian, White, etc.
dia.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates		1 ☐ Yes 2 █No Specify:		Specify:	DIACE
an Ex		15. Decedent's E		16a. Dec	edent's Usual Occupation	1	6b. Kind of Busin	BLACK ness/industry
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E E	Сош	7			CUSTODIAN		G. W. UN	IVERSITY
event, II	Be (	17. Father's Name (First, Middle, Last	")		18. Mother's N	ame (First, Middle, M	laiden Sumame)	
umatic ev	은	HAPPLE	HERR			LEVI	CRUMPLE	
any injury or ether traumatic evonce.		19a. Informant's Name/Relationship (			ling Address (Street and Number or F			ate, Zip Code)
ther		ROSA HORTON HE  20a. Method of Disposition	KKING/WIF	20b. Place of Disp				ty or Town, State
30		1 Burial 2 Tremation 3	Removal from Stat	(Θ	ematory or other place)			
injur,		* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice)			RS CREMATORY 11— 22. Name and Address of Facility		RIVERDA	
any onc		1/2///////////////////////////////////	amlers	M00091	CHAMBERS FUNERAL 801 CLEVELAND AV	HOME & CRI	MATORIU	M,P.A.
iner								
	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijer) that initiated events resulting in death) Last	c.	as a consequence of):				
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State of Maryland / Department of Health and Mental Hygien 2 0 0 L 38389 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 14, 2004 **Physician** POSNER HAKEN 8:50P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11623 Lebaron Terrace Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 29, 1914 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 1 ☐ M 2 😿 F Yrs. Director 90 096-09-5717 New York Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits ? Is marked other than "natural", or Itams 23a or 28a-f show traumatic evant, the Madical Exertir or must be rigitized at Maryland Silver Spring Director Montgomery 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8817 Sundale Drive 20910 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or iter 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Completed by White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1-4 Office Administration Patent Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Posner Jenny Rabinkof ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11623 Lebaron Terrace Silver Spring, Maryland20902 Item 27 i Gail R. Haken -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Beth David Cemetery NOV.16,2004 Elmont, New York Service Licensee 21. Signature Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician COKONARY HEART YEARS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day 4□Pregnant at time of death 5 Cther (specify) Division of Vital Records, P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24a. Was an autopsy performed? 1 ☐ Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Other: 4 Nursing Home 5 Residence 6 Mother Beauthters Residence Hospital: 2 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 15, 2004 DO 9834 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry N. Rosenbaum, M.D. 3720 Farragut Avenue Kensington, Maryland 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 17 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 38390 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Nov. **Physician** 11, 2004 0830 Margaret Hanson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner l Medical Center 6. Sex 7. Age (In yrs. last birthday) Anne Arundel Annapolis Year Munder 24 Hrs. Anne Arundel Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 🗙 F Director 87 4, Dec. ΚY 402-10-2022 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County in then "natural", or itams 23a or 28e-f show the Medical Exproprer must be notified at MD Anne Arundel Gambrills 1 ☐ Yes 2 🖁 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21054 2605 Chapel Lake Drive USA death \ by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or item any injury or other treumatic event, Ite Medical Exemples, once. Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lawrence Keller Agnas Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Hall/Daughter 1788 Meade Court, Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov. 20045, 1 

Burial 2 □ Cremation 3 □ Removal from State Millersville, MD Our Lady of the Fields \* 4 □ Donation 5 □ Other (Specify) 2Barranco & Sons, P.A. Severna Park Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death Immediate Cause (Final Inta cevebral Hemorrhage Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 1 Ninpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After ' the Hospitei or Attending 1 KNatural Injury 5 Pending death. investigation 2 ☐ Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funerail 29a. Certifier 1 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 SperolBech, Hus 46052 11/11/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loo! Wholical Parkway, annapolity, MD 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 6 2004 Registrar

riease Type of Print in Black indelible ink. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygien 0 0 4	0000
Certificate of Death	3835

			1 - For State Registrar	Otate of Mic	Ce.	rtificate of L			2 0 (	] [4	38391
	Physici /Medi		Decedent's Name (First, Middle, La     Baba	tunde	Iluy	emi		2. Date of Dea Month Novembe	er 16,	2004	3. Time of Death
	Examir		4a. Facility Name (If not institution, given 1907 Erie Street			4b. City, Town, or Adelphi	Location of Death	I	4c. County	of Death	orges
	Funeral Director		None	Sex 7. Age 1 <b>X</b> M 2□ F	e (In yrs. last birthday) 20 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day August	Year)	9. Birthp	place (State or Foreign htry) S, Nigeria
	laryland show	or.	Usual Residence of Decedent  10a. State  10b. County  District of Col		10c. City, Town or Lo					1	0d. Inside City Limits 1 X Yes 2 □ No
	he N	ect	10e. Street and Number	ишота	Wash	ington					
	th with 1 23e or 3	al Dir	702 Decatur St	reet, N. E.		10f. Zip Code 200	17		10g. Citizen of V <b>Nigeria</b>		t <b>Africa</b>
980	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "neturel", or Items 23e or 28e-f show event. The Madical Examiner must be mailted at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent 8 Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:	lo	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (Spanic Origin? (Spanic Origin), Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americk, White,	
Maryland 21215-0036	within 72 ho ene. than "netur re Medical	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	ation furing most of worki )	ing	16b. Kind of Bu		dustry
2	filed within Hygiene. other than sent, the M		12th grade  17. Father's Name (First, Middle, Las.		De.	Liveryman	40 Markada Nasa		Pizza		
/lanc	2 should be filed and Mental Hygid Is marked other aumatic event, II	To Be		anga			18. Mother's Name	e (First, Middle, i ju Adio		76)	
Mary	s 1 and 2 should f Health and Men item 27 Is marke other traumatic	ľ	19a. Informant's Name/Relationship Caprice Iluyemi	Type Print) (Wife) &		ng Address (Street a					
Baltimore,	m O		Edekin Eruanga (1 20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Place of Dispo	Decatur S sition (Name of natory or other place	Nov.		20c. Location -		
tim	t. Pa rtmen rtant: njury		`4 □ Donation 5 □ Other (Speci	(y)		ke Cremat	tory, Inc	•	Beltsv:	ille,	Maryland
Bal	permi Depar Impor eny ir		21. Signature of Funeral Service Lice	and the second	I I	Name and Addres N. Hort OO Kenned	on Compa	ny Morti	icians,	Inc.	0 00011
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Hu	the death. Do not ent	er the mode of dying	g, such as cardiac c	or respiratory arre	est,		Approximate Interval Between Onset and Death
	cuted nd ransit	Examiner	Sequentially list conditions, it any, reaching to inmove access. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	t consequence of):						
68760,	certificate be executed rding physician and use as the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a	a consequence of):						
.O. Box 6	death cer e aftendir id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delive	ry Day Year
S, D	law requires that the de as been signed by the a 2 should be detached	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	SV.		e cause of death?
of Vital Record	The ate his	Completed						24a. Was ar autops perform 1 Yes 2	y ned? d	rior to con leath?	osy findings available npletion of cause of 2 \square
Vita	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death				7.1
	ing Witer	-	1 XYes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	1 ☐ Inpatier 28a. Date of Injun (Morth, Day	Year) 28b. Time of Injury	28c. Injury Work	4   Hursing Hor	me 5 Reside 28d. Describe ho			) At scene
Division	in Digital	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, str (Specify)			28f. Location Str City or Town	1, State) ( 9,	07 E	rie Street
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ★ Medical Example (Check only one)	nysician: To the best of miner: On the basis of and manner stat	examination and/or inv	occurred at the time restigation, in my opi	e, date and place, a inion, death occurre	and due to the ca ed at the time, da	use(s) and mai ate and place, a	nner as sta and due to	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		1	29c. License		29	9d. Date signed	(Month, D	ay, Year)
'	00		30. Name and address of person who	allan l	nath (Itam 22a) (Time	O.C.M	.E.		July 17	, 200	14
			CAROL H. A	A . )		Penn Stre	et, Balti	more, M	aryland	2120	)1

Registrar

31. Date filed (Month, Day, Year)
NOV 1 9 2004

			1- State of Maryland / Depa	rtment of Health and Mitificate of Death		/ 11 11 13	38392
<i>}</i> :	<b></b>	_	Registrar  1. Decedent's Name (First, Middle, Last)	incate of Beatif	2. Date of Dea	ieg. No.	3. Time of Death
П	Physici		Isabelle F. Johnson		Month Nov.	15, 2004	3:30 P M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	110 4 .	4c. County of Deat	
			Cherry Lane Nursing Home	Laurel		Prince Ge	
	, Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Will all and the state of	8. Date of Birth (Month, Day		nplace (State or Foreign untry)
	Director		262-22-7896 1 M 2 F 86 Yrs.	Months Days Hours Min.	11 27	17 Bris	stol, FL.
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Loc	ration			
	fanyla sho	ō	MD Prince Georges Laurel	ation			10d. Inside City Limits  †☐ Yes 2 ☐ No
	28a-i	Director	10e. Street and Number	10f. Zip Code		10- 00	
	with Se or	2				log. Citizen of What Co	intry?
	leath	Funeral	9001 Cherrywood Lane  11. Marital Status  12. Was Decedent Ever in U.S.  13. W	20707	cify Yes or No-	USA 14. Race - Amer	ican Indian
(0	ifter o	Fun	Armed Forces? If	/as Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White	
ဗ္ဗ	el', o	þ	3 ☐ Widowed 4 ⊠Divorced If Yes, Give Year or Dates:	☐ Yes 2☑ No Specify:		Specify: Bla	ck
2-0	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28a-f show te Madical Examitter is use to restitled at	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation aind of work done during most of working		16b. Kind of Business/I	ndustry
2	ithin Je.	ldu	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)	-	Tindell Fie	1d
2	filed w Hygier other tl ent, tc			dry Worker		Air Force B	ase
Maryland 21215-0036	be fi	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		Maiden Sumame)	
Ĕ	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other then "neturel; or Items 23s or 28a-f show eumatic event, it e Mudical Examilter in the Intilitied at	ဥ	Buford Fennell  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	Marie Eu			
<u>S</u>	id 2 s th an th an treu		Lancava.co	g Address (Street and Number or Rural			p Code)
ē,	Heal Heal tem		20a. Method of Disposition 20b. Place of Disposi	Madison St. Hyatts		Md 20782 20c. Location - City or 1	own. State
OF.	ages ant of t: If i		1 23 Bunal 2 Cremation 3 Hemoval from State	atory or other place) ill Cemetery 11-20			
altimore,	artme orter injur		The state of the s	Name and Address of Facility Mars		Port St. Jo	
ä	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic es one.		1 10	217 9th. St. N.W.			
			23a. Part Enter the disease, or complications that caused the death. Do not enter shook, or heart failure. List only one cause on each line.				Approximate
	Pnysician	) 	Immediate Cause (Final disease or condition Pneumo				Interval Between Onset and Death
	/Medical		resulting in death)  a			=======================================	
	Examiner		Sequentially list conditions, b				
9	D #	iner	fl any, leading to immediate cause. Enter Underlying Cause, Disease or injury				
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):				
8760,	ficate be executed physician and s the burial-transit	al E	bue to (or as a consequence of).				
287	death certificate be executed e attending physician and id for use as the burial-transit	edlcal	d				
Rox	leath certific attending p	lan/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	erv
ň	death e atte	icla	in the past 12 months?  1 Ves 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
o.	t the by the	hysici	9 ☐ Unknown				
S,	w requires that the d been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did tob	acco use contribute to I	he cause of death?
D.C	equir en si ould l		Dementia		1 □ Ye	s 21⊠No 3∏Pro	pably 4 □Unknown
Kecords,	B SO	ompleted			24a. Was ar		ppsy findings available impletion of cause of
	sician: The la certificate ha irector, page 2	Соп			perform	ned?   death?	
VII	ysician: is certific director,	Be	25. Was case referred to medical examiner?	26. Place of Death	Check only on	9)	
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	ing Ifter Innel	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	ld. Describe ho	w injury occurred	
UNISION	Attending r death. sctor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	of Leasting (Ct		10
2	lor At after o Direc	ertification:	4 Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	er, lactory, office	City or Town	reet and Number or Run , State)	Il Houte Number,
	e Hospitel or Attendi 124 hours after death. The Funerel Director: A letely filled in by the fu	O	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death of	occurred at the time, date and place, an	d due to the ca	usa(s) and manner as a	tated
	To the Hos within 24 h To the Fur completely	dical	(Check only 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred	at the time, da	ite and place, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month,	Day, Year)
	1/2		I "Oh shelld	D56797		11-17-04	
120	0/2/		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	rint)			
			Lalitha Tadikonda, MD, 13952 Baltime	ore Ave., Laurel,	MD. 207	707	
	Sta Registra	175	NOV 1 9 2004 (Month) (Month) (Month) (Month) (Month)				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death

38393

Physician /Medical	1	REVA ANN GRE	1000000	e car						1	OVEMBER		004 Year	2:55 A
Examiner		la. Facility Name (If not CHARLES COUN	nstitution, give TY NURS	street and nur NG & REH	nber) ABILT	TATION CIR	4b. City		r Location	of Death		4c. C	County of De	ath
Funeral Director		5. Social Security Number 227–42–1680		ex □M 2 <b>X</b> 1F	7. Age (	'In yrs. last birthday, Yrs.		Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	, 1906	9. B	irthplace (State or Foreign AY, VIRGINIA
D .	-	Usual Residence of Dec	County		1	Oc. City, Town or L	conting							10d. Inside City Limit
ith the Marylar or 28a-1 show			ARLES			BRYANS ROAD								1 XYes 2□N
3a or 28		10e. Street and Number 6530 MATTHEWS	ROAD				10f. Zi	p Code 16				11.55	en of What (	
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Exercises crust be notified at once.  To Re Commissed by Finneral Director		11. Marital Status 1 □ Never Married 3 🏿 Widowed 4 □	_	12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	rces? 2 <b>X</b> ⊡No ∕e	er in U.S. 13.	Was Dece If Yes, spe 1 Yes		ispanic Or an, Mexica Specify		cify Yes or No Rican, etc.)		Black, Wh	nerican Indian, nite, etc.
ed within 72 hours a ygiene.  Per than "natural", of the Modical and the Modic	-	(Specify or		ducation de completed) College (1	-4or 5+)	16a. Dece (Give life.	dent's Usu kind of wi DO NOT i	ial Occupi ork done d use retired	ation during mo: f)	st of workir	ng	16b. Kind	d of Busines	ss/Industry
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tal Hyg d othe event,	3	17. Father's Name (First,	Middle, Last)				-		18. Moth	er's Name	(First, Middle	, Maiden S	iumame)	
Menta Menta arked artic ev	3	JOHN F. GREEN							LOUIS	A BANK	S GREEN			
nd 2 shou lith and M 27 is mar r traumat		19a. Informant's Name/F					-				Route Numb		Town, State	, Zip Code)
Pages 1 are tent of Hee nut: If Item ry or other		20a. Method of Disposition  1 Burial 2 Cre  4 Donation 5	mation 3	Removal from	State	20b. Place of Disponential CE	matory or	other plac			ate IR 20,20			or Town, State
permit. Departm Importa any inju		21. Signature of Funeral	Service Leer	SOUND ON	~	M00583 3	HORNIC 439 LI	W NES	ERAL I	ΜE, I	DIAN HE	AD, MD	20640	
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ath cer attendir or use	-	IF FEMALE: 23b. Was decedent pred in the past 12 month			irth 2	Fetal death 3	⊒Ectopic p					23	3d. Date of d Month	elivery Day Year
	-	1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant	conditions	9□ Unkno	own				on in Part		23e Did t	obacco use	e contribute	to the cause of death?
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has b	2										24a. Was autoj perfo	an osy ormed? 2 No	24b. Were a prior to death?	autopsy findings availab o completion of cause of os 2 \(\sum \) No
ician: Thi certificate rector, pag	)	25. Was case referred to examiner?	medical						26. Plac	of Death	(Check only o	ne)		
S G	)	1 Yes 2 No		Hospital: 1 □ I	npatient	2 ER/Outpatie	nt 3 D	OA Oth	er: 4 N	ursing H <i>o</i> n	ne 5 ☐ Resi	dence 6	□Other (Sp	ecify)
ting After fune		2 Accident	Pending investigation		of Injury th, Day Y	/ear) 28b. Time of Injury	of M	28c. Injun Worl	yat k? Yes 2 ⊡		8d. Describe	how injury	occurred .	
spital or Attending Pours after death. Inter Director: After if filled in by the funeral Certification.		3 ☐ Suicide 6 [ 4 ☐ Homicide	Could not be determined	288. Place		y - At home, farm, st (Specify)	reet, factor	y, office		2	28f. Location ( City or To		Number or F	Rural Route Number,
Hospi 4 hou Funer sely fill					asis of e	my knowledge, deal xamination and/or in d.								
To the Hos within 24 h To the Fur completely		29b. Signature and title	of Sertifier	Par			29	c. Licenso	s number		mo	29d. Date	signed (Mar	nth, Day, Year)
NR5		30. Name and address of	person whi	impleted caus	e of dea	th (Item 23a) (Type	Print)	nte	W	iHuf.	Moruk	and	. 4 10	-1
State		31. Date filed (Month, Da	A 1894	2004 32. R	gistrar'	s Signature	Land	4						

			1 For State Registrar	State of Ma	ryland /		artment <i>tificate</i>			and M	-	giene	1001	· ~	22201.	
			Decedent's Name (First, Middle, Las	1)			imouro		-		2. Date of De		004	3	3. Time of Death	_
	Physic		Kathleen	Marie	Кар	inos					Novemb	er 28	g, 2ŎÖ	Z	1:55am M	1
	/Medi Exami		4a. Facility Name (If not institution, give	street and number)			4b. City, To	own, or	Location o	f Death			County of De		1.00011	-
			Kline Hospice Ho	use			Mou	nt A	Airy				Frede	rick		
	Funeral		5. Social Security Number 6. Se 028–18–4173	x 7. Age ☐M 2/√DNF	(In yrs. last I		If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Mar 4,	th ay, Year)	9. E	Birthplace	e (State or Foreign	7
	Director		Usual Residence of Decedent		80	Yrs.					Mar 4,	192	4 Cc	nné	cticut	
	/land		10a. State 10b. County		10c. City, To	wn or Lo	cation							10d.	tnside City Limits	-
	Man a-f sh	tor	Maryland Frederi	ck	Fr	ceder	ick								1X Yes 2 □ No	
	within 72 hours after death with the Maryland ene than "natural", or itams 23a or 28a-f show the Madical Examinar must be multified at	Director	10e. Street and Number			-	10f. Zip C					10g. Citi:	zen of What	Country?	?	-
	ath w	a	8323 Jordan Vall	ey Way				2	2 <b>17</b> 02			J	J.S.A.			
	er dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Deceder Yes, specifi	nt of His y Cubar	spanic Orig	in? (Spe Puerto I	cify Yes or No Rican, etc.)	. 1	14. Race - An Black, Wi			
36	rs aft		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ₩ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	0	1	☐ Yes 2							Whit		
21215-0036	72 hours "natural", dical Exa	led	15. Decedent's Edu	ucation	16	a. Deced	ent's Usual	Occupa	tion			16b Kir	nd of Busines			_
218	d within 72 ho jiene. r than "natur ine Modical	ple	(Specify only highest grad Elementary/Secondary (0-12)	fe completed) College (1-4or 5+		(Give I	kind of work OO NOT use	done di retired)	uring most	of workir	ng	100.14	14 01 04311163	is/indust	y	
	filed with Hygien of the the the sant. It is	Completed by	12			Supe	rviso	r				Fo	od Sei	vic	e	
nd	ed a b	Be	17. Father's Name (First, Middle, Last)	D.	1						(First, Middle,		,			
7	should and Men amarke	To	Stephen		ozok					resa		zabet			elrock	
Maryland	s 1 and 2 shoul f Health and Mitam 27 ia marl other traumati		Joyce E. Connelly	· .							Route Number				d 2 <b>17</b> 02	
	Heal Heal tam 2		20a. Method of Disposition	, badgiitet	20b. Place cemet	of Dispos	ition (Name	of of	illey		ate		ation - City o			_
Baltimore,	m 0 .		1 🕅 Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)				atory or other. Ceme			- 1	2004				aryland	
alti	# 문문를		21. Signature of Funeral Service Licens		110 02			_			.A. Fur			, 116	aryrand	
m	Depa Impo any id	1 1	the how kitse	en M	00706	10	6 Eas	t Ch	urch	St.	Freder	ierai ick.	. ноте MD 2 <b>1</b>	701		
U			23a. Part1. Enter the disease, or compleshock, or heaft failure. List only o	ications that caused t ne cause on each line	he death. Do	not ente	r the mode o	of dying,	, such as c	ardiac or	respiratory ar	rest,		App	proximate erval Between	_
	Physician		tmmediate Cause (Final disease or condition	. H4	m120	cho	3411	(	600Z	+	Hac				set and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):	1				11.7			1	occ.)	F
		10	Sequentially list conditions,	Due to (or as a	CONSEQUENCE	24	on	0	7					40	ass	_
K.	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		ponocydonoc	γ.,.								1		
o,	exect an and rial-tra	Exa	resulting in death) Last	Due to (or as a	consequence	of):										_
8760,	cate be executed physician and the burial-transit	dical		d											· · · · · · · · · · · · · · · · · · ·	
9	ing ph	Med	IF FEMALE:												7	_
Box	death certific e attending p id for use as	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth 2	Fetal deat		Ectopic preg	папсу				23	3d. Date of de			
0.		Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of death	5 🗌	Other (speci	ify)					Month	Day	Year	
٥.	The law requires that the do the has been signed by the page 2 should be detached	/Ph	Part II. Other significant conditions cqu	ntributing to death but	not resulting	in the und	derlying caus	se aiven	in Part I.		23e. Did to	bacco us	e contribute t	o the ca	use of death?	
Vital Records,	quires n sign ald be	d by	Disheter Mally	astu De T	1_		, ,	J			1 □ Y		_		4 Unknown	
CO	aw require as been sig 2 should b	Completed	Cosmaco	THOU	75.	115	P				24a. Was a	an	24h Were a	utoney fi	indings available	_
Re	The fav te has age 2	E O	Action	11 0/2	1	agen )	$\succ$			_	autop	sy med?	prior to death?	complet	tion of cause of	
ital		BeC	25. Was case referred to medical examiner?	TE NYP	quen	180	1		26. Place o	of Death	1 □ Yes (Check only &	2 No	1 🗆 Ye	s 2 🗆	No Contraction	_
of <	Physician: this certific ral director,	To E	1 Yes 2 46	lospital: 1 🗆 Inpatient	2 🗆 ER/O	utpatient	3□ DOA	Other			e 5 Resid		Other (Spe	ecify)	10,000	
	ding P h. After t funera	ion:	27. Manual Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day 1		Time of Injury		Injury a Work?			3d. Describe h	ow injury	occurred		1. 013	-
<u>s</u>	Attanding ir death. actor: After by the funer	icat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	One Place of Laive			М		s 2 □ No	-						
Division	lor A after Dirac	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	(Specify)	arm, stree	et, factory, of	fice		28	3f. Location (S City or Tow	treet and n, State)	Number or R	ural Rou	ite Number,	
	Hospital or Attano 24 hours after deati Funaral Diractor: tely filled in by the	aic	29a. Certifier 1 Certifying Phys	sician: To the best of	my knowledg	e, death (	occurred at t	he time	date and	place, an	nd due to the c	auso(s) a	nd manner a	hotets a		_
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edicai	(Check only 2 Medical Examination)	ner: On the basis of e	xamimation at	nd/or inve	stigation, in	my opir	ion, death	occurred	d at the time, d	ate and p	lace, and due	o to the	cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	/ //	1.12		29c. Li	icense r	number		2	9d. Date	signed (Mon	h, Day,	Year)	_
ŀ			MANIA	VM !	2)			D1	6428			111	29/04	,		
	1		30. Name a darress person who c					C.L	100 C.F.	E-	J 1	34		04-	0.1	
	Sta	te ·	Casper E. Cline,	32. Registrar's		vest	MTUEN	ot!	reet,	rre	derick	, Matr	yrand	21/	01	
	- Jia		MER A 9 20	MA NA		E	1	Show								- 1

			1 - For RegistraMEND#19bperFH11	State of Marylar	nd / Depa <i>Cei</i>		of Health an		giene Reg. No.200	4 38395
	Physici		Decedent's Name (First, Middle, Last)     Ruth Kane					2. Date of Dea Month November	Day Yes	3. Time of Death 6:00 P. M
	/Medie Examir		4a. Facility Name (If not institution, give s Mariner Health Care			Wheat		Death	4c. County of D	eath
	Funeral Director		5. Social Security Number 6. Sex 087-01-6132	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Y Months D		Min. 8. Date of Birth (Month, Day August 3)	7, Year) 0, 1916 No	Birthplace (State or Foreign Country) EW Jersey
	Maryland a-f show	tor	10a. State 10b. County Maryland Montgomer		ty, Town or Lo nevy Ch					10d. Inside City Limits 1X Yes 2 □ No
	3a or 28	il Direc	10e. Street and Number 3535 Chevy Chase I	ake Drive #	107	10f. Zip Co	de 10815		10g. Citizen of What	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department or Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itema 23e or 28e-f show any injury or other treumatic event, the Medical Exaction could be notified at ance.	by Funeral Director		12. Was Decedent Ever in U Armed Forces? 1  Yes 2 XNo If Yes, Give Year or Dates:	l.S. 13. V	-	of Hispanic Origin Cuban, Mexican, P	9? (Specify Yes or No- Puerto Rican, etc.)	14. Race - A Black, W	merican Indian,
1215-0	within 72 ho ine. :han "natui a Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	OO NOT use re	one durina most of	f working	16b. Kind of Busine Own Home	
Maryland 21215-0036	uld be filed v fental Hygie rked other t tic event, to	To Be Co	12 17. Father's Name (First, Middle, Last) Duncan MacGillivr	ay	Home	emaker	18. Mother's Esth	Name (First, Middle, er Jackso	Maiden Sumame)	
	alth and N		19a. Informant's Name/Relationship (Type Sue Mitchell/ Daug		19b. Mailin 3535 -	CHOVY CHOVY 9 Addless (St	reet and Number of Nase Dr Chase Dr	The #107,	r, City or Town, State Chevy Cha	se, MD 20815
Baltimore,	Pages 1 ament of He ent: If itam		20a. Method of Disposition  1 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)	20b. F Geo Me	Place of Dispos cemetery, crem TGETOWI ECICAL (	sition (Name of patory or other Unive Center	no No	vember12 2004	20c. Location - City Washingto	
Balt	permit. Departs Import any inj		2) Signature of Juneral Strvice License		22		ddress of Facility	ry Service Washington	s,Dinc.20	037
8760,	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	23a. Part. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listease or injury that initiated events resulting in death) Last  d. d.	e cause on each line.  Congestive  Due to (or as a conseq	Heart I			diac or respiratory arr	est,	Approximate Interval Between Onset and Death
P.O. Box 6	that the death certific led by the attending p detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 24 No 9 □ Unknown	Bc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregni Other <i>(specif</i> )			23d. Date of o	lelivery Day Year
	juires that I n signed by ild be deta	by	Part II. Other significant conditions cont Chronic Obstructiv				given in Part I.			to the cause of death?
tal Records,	ysician: The law requir is certificate has been si director, page 2 should	e Completed	25. Was case referred to medical					24a. Was a autops perforn 1 Yes 2	y prior to ned? death' 2⊠No 1 □ Ye	
>	Physicia this cert al direct	To B	eyaminer?	ospital:	ER/Outpatient	3□ DOA	Oth	Death Check onl on ng Home 5 Reside		pecify)
Division of Vital	ding I h. After funer		27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Work? 1 □ Yes 2 □ No		w injury occurred	,
Ď N	<u>P</u> affe o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, off	ce	28f. Location (St. City or Town	reet and Number or i n, State)	Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral i completely filled	Medical	29a. Certifier (Check only one) 12 Certifying Physical Examine one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at the estigation, in n	e time, date and pl ny opinion, death o	lace, and due to the ca occurred at the time, da	ause(s) and manner ate and place, and de	as stated. ue to the cause(s)
•	2	2	29b. Signature and title of certifier	Sogil	In	_	ense number 2261		Od. Date signed (Mon November	
			30. Name and address of person who com				+1 C	-i 10 0	2006	
	Sta Registr		Alan R. Segal, 31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	Sour		ring, MD 20	J906	

233 Florida Ave., Salisbury, MD 21801

SIA

State Registrar Inja J.

31. Date filed (Month

Hwang

16

2004

'nďv

32. Registrar's Signature

		Registrar  1. Decedent's Name (First, Middle,	State of M		Certificate of	Death	Reg	. No. 2 0 0 4	3839
Physic Medi/		Laura	Elizabeth	Myers	3		Month NOVEMBE	Day Yee R 23, 200	r
Exami		4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of Death		4c. County of De	
		MEMORIAL HOSPIT  5. Social Security Number		ge (In yrs. last bir	CUMBERL.		8. Date of Birth	ALLEGAN	
uneral irector		233-66-7372 Usual Residence of Decedent	104 005		Yrs. Months Days		Jan 5, 19	912	irthplace (State or For Country)
r show	ō	10a. State 10b. County MD Alleg	any	10c. City, Tow	n or Location umberland				10d. Inside City Lin
or 28e-	Funeral Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What (	
18 23e	erai	220 Somerville A	12. Was Decedent			21502	- 4.0	USA	
d other than "natural", or itams 23a or 28a-1 show avent, the Medical Examinational be nutified at	by Fun	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?	7	13. Was Decedent of If Yes, specify Cub		ecny Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	nite, etc.
"natura	Completed by	15. Decedent's (Specify only highest	s Education grade completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work	ing .   16	b. Kind of Busines	
The	omo	Elementary/Secondary (0-12)	College (1-4or		orer	30)		acking Co	mpany
d other avent, I	BeC	17. Father's Name (First, Middle, L	•			18. Mother's Name	e (First, Middle, Ma		, ,
	To	Gurt Hillery Ba					(Mulledy)		
27 Is r trau		19a. Informant's Name/Relationshi William Myers	<sub>ip (Турв, Print)</sub> granc	dson 1	Mailing Address (Street 0908 Rawley	t and Number or Run <b>/ Road</b>	al Route Number, C New Ma		Zip Code) 1D 21774
ant: if Itam 2 ury or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cemeter	Disposition (Name of ry, crematory or other plated Cemetery	ice)	Date 20 11/26/2004 (	c. Location - City o	r Town, State
Important: any injury o		21. Signature of Funeral Service Li		110	22. Name and Addre			JIGLOWII	IVID
	$\vdash$	23a. Part1. Enter the disease, or d	complications that cause	d the death Dov	108 Viro	ginia Avenue	: Cumberlar	nd, MD 2150	)2 Approximate
sician edical		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	niy one cause on each ii	ine.	AL INFARCTI		or respiratory arrest	,	Interval Betweer Onset and Deat
miner		Sequentially list conditions,		a consequence of NTESTINA					6 DAYS
sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o					0 21110
nysicien and he burial-transit	ıl Examiner	that initiated events resulting in death) Last	c. DEMENTI Due to (or as	A consequence of	of):			_	
the state	ledical		d						
the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	olivery Day Year
> 0	by Pr	Part II. Other significant condition	s contributing to death b	ut not resulting in	the underlying cause gr	ven in Part I.			o the cause of death?
n signed by the a uld be detached f									
has beer je 2 shou							24a. Was an autopsy	prior to	utopsy findings availa completion of cause
ate has beer page 2 shou	e Completed	25. Was case referred to medical				OS Plans of Doorl	autopsy performed 1 Yes 2	prior to death?	completion of cause
is certificate has beer director, page 2 shou	Be Completed	25. Was case referred to medical examiner? 1 ☐ Yes 2♥ No	Hospital: 🏚 Inpatie	ent 2 □ ER/Out	tpatient 3□ DOA Oth	26. Place of Death	autopsy performed 1 Yes 2 Check on one)	d? prior to death? No 1 □ Ye	completion of cause s 2□ No
After this certificate has beer funeral director, page 2 shou	To Be Completed	examiner?	28a. Date of Inju (Month, Da		ime of 28c. Injury Wor	ner: 4 ☐ Nursing Hor	autopsy performed 1 Yes 2	d? prior to death? I No 1 □ Yes	completion of cause s 2 □ No
After this certificate has beer funeral director, page 2 shou	To Be Completed	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry Year) 28b. T	ime of 28c. Injury Wor	oner: 4 □ Nursing Hory at tk? Yes 2 □ No	autopsy performed 1 Yes 2 1 Check on one)  The 5 Residence	prior to death?  No 1 Yes  e 6 Other (Special injury occurred)	completion of cause s 2□ No ecify)
After this certificate has beer funeral director, page 2 shou	Certification: To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no determin  29a Certifier 1 Certifying	28a. Date of Inju (Month, Da)  28b. Place of Inju building, etc  Physician: To the best xaminer: On the basis of	ury - At home, far c. (Specify)	ime of piury M 1 1 mm, street, factory, office	ner: 4 □ Nursing Hory at tk? Yes 2 □ No	autopsy performed.  1 Yes 21/2  1 Check on one)  me 5 Residence 28d. Describe how in the cause of the cause o	prior to death?  No 1 Yes  e 6 Other (Special injury occurred at and Number or Ritate)	completion of cause s 2 No scify)  ural Route Number,
this certificate has beer al director, page 2 shou	To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga  2 Accident 6 Could no determin  29a. Certifier 1 Certifying (Check only 2 Medical Expression)	28a. Date of Inju (Month, Da) ation by be 28e. Place of Inju building, etc.	ury - At home, far c. (Specify)	ime of piury M 1 1 mm, street, factory, office	ner: 4 Nursing Hor y at k? Yes 2 No	autopsy performe.  1 Yes 22  1 Check on one)  me 5 Residence 28d. Describe how in the cause of at the time, date	prior to death?  No 1 Yes  e 6 Other (Special injury occurred at and Number or Ritate)	s stated. a to the cause(s)
After this certificate has beer funeral director, page 2 shou	edical Certification; To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga  2 Accident 6 Could no determin  29a. Certifier (Check only one)  1 Certifying 2 Medical Est	28a. Date of Inju (Month, Da)  28b. Place of Inju building, etc  Physician: To the best xaminer: On the basis of	ury - At home, far c. (Specify)	ime of 28c. Injury Wo M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ner: 4 Nursing Hor y at k? Yes 2 No	autopsy performe.  1 Yes 22  1 Check on one)  me 5 Residence 28d. Describe how in the cause of at the time, date	e 6 Other (Spaninjury occurred  at and Number or R  e(s) and manner a and place, and during the stand of the	completion of cause is 2 \( \text{No} \)  secify)  fural Route Number,  s stated, s to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** TOSE Month /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Kock UI IIE 4c. County of Death **Examiner** MONTGOMEN HOUSE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Days 88-8873 1**■**M 2□F Hours Yrs. Director COLOMBIA Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at MONTGOMER Director GERMANTOWN 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? STONE HOLLOW or Items 23e 4. S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 271s marked other then "neturel", or Item any injury or other treumatic event. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1≱Yes 2□ No Specify: whITE 3 Widowed 4 Divorced COLOMBIAN Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

LABORER 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname CEFERINO MESA 19a. Informant's Name/Relationship (Type, Print) DA49h (2-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18462 STONE HULLOW DR MESA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State CHAMBERS Cremasury \* 4 □ Donation 5 □ Other (Specify) FUNERAL SUE POBGIT STEELING WA Approximate Interval Between Onset and Death **Physician** /Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ STENOSIS 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performed this certificate 2.2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 HOther (Specify) HUSAICE 1 ☐ Yes 2 € No Medicai Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 -Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death | Director: / d in by the f 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel E 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier DR 4216114 no completed cause of death (Item 23a) (Type, Print) Prime Phillip DR GINEY MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Mon

32 Registrar's Signature

		ı	1 - For State Registrar	State of Maryla		artment rtificate				ene 004	38399
	Physic		1. Decedent's Name (First, Middle, Last	horeland					2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give University of Mary).		1ter		own, or L	ocation of Death	Novemb	4c. County of De BAHim	ath
	Funeral Director		213-22-0858	7. Age ( <i>In yr</i> s)	. last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) MAR • 14	Year) 9. B	rthplace (State or Foreign Country)
	yland how		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	Director	MARYLAND CHA	ARLES L	A PLAT						1 ☐ Yes 2/Q/No
	3a or		7382 ST. MARY'S	S AVE.		10f. Zip 0		.0646	10	g. Citizen of What C	
036	hours after deat .ural', or itams 2 al Exemineceu	by Funerai	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: 1945		Was Decede f Yes, specif	nt of Hisp y Cuban,		pecify Yes or No- pecify Yes or No- pecify Yes or No-	U.S.A 14. Race - Arr Black, Wh Specify:	erican Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after de to Health and Mental Hygiene. If item 27 Is marked other than "natural", or Itam or other traumatic event, Ire Medical Evantical.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	DO NOT use	done dui retired)	ring most of wor	king 1	Sb. Kind of Busines: MARYLANI HIGHWAY	STATE
pue	be file stal Hyg ad othe event,	Be	17. Father's Name (First, Middle, Last)	C.D.	- III, N	ı ıyı	1	8. Mother's Naп	ne (First, Middle, Ma	aiden Sumame)	ADMIN.
Maryland	should nd Mer marke	70	ERNEST MORELANI  19a. Informant's Name/Relationship (7)		19b. Mailin	a Address (			JENKINS		Zin Codel
	1 and 2. Health au Iem 27 Is		LOUISE MORELAND	-WIFE	7382	ST.	MAR		E. LA		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		20a. Method of Disposition  14△ Burial 2 □ Cremation 3 □	Removal from State	Place of Dispos cemetery, crem	natory or oth	er place)		Date 20	c. Location - City o	Town, State
altir	permit. Pa Departmen Important: any injury once.		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		22	. Name and	Address			VALDORF,	MD
<b>B</b>	nap Pen		23a. Part 1. Exter the disease, or comp	0.8	X	RAYMC <del>La Pi</del>	ND ATA	FUNERA <del>, Mary</del>	L SERVIO	CE, P.A.	
	Physician /Medical		23a. Part 1. Enjer the disease, or comp shook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Middle Ceret	oral Art	ery is			4	~	Approximate Interval Between Onset and Death 3 days
8760,	cate be executed by sician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	,						
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3 🗌	Ectopic preg Other (spec				23d. Date of de Month	livery Day Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the un	derlying cau	se given i	in Part I.	23e. Did tobad	V	o the cause of death?
		Completed							24a. Was an autopsy performed 1 Pes 2	24b. Were at prior to death?	utopsy findings available completion of cause of 2 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1. ✓ Yes 2 □ No	Hospital: 1  Inpatient 2 □	ER/Outpatient	3 🗆 DOA	04		n <i>(Check only one)</i> me 5 ☐ Residenc	o 6 □0th or /0-	
Division of	ing Ph	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe how		ciry)
5	tal or Attend s after death al Diractor: , ad in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, o	ffice		28f. Location (Stree City or Town, S	et and Number or Ro State)	ural Route Number,
	To tha Hospital or J within 24 hours after To tha Funeral Dira completely filled in b	Medicai (	29a. Certifier (Check only one) 1 Certifying Phy	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at estigation, in	he time, my opini	date and place, on, death occurr	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	Ž	29b. Signature and title of certifier			29c. L	icense nu	umber		Date signed (Mont	
	1		30. Name and address of person who co	M. D.	23a) (Tues 5	(rint)	165	> 89	l N	lovember 2	13,2014
1	<u>^</u>		Sangjin Oh 23	L South Greone	Street		altin	nove t	laryland	21201	
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 3 2	32. Registrar's Signa	ture A						

	1 - For State Registrar	State of Man	yland / Depa <i>Cei</i>	artment of H	ealth and	Mental Hyg	iene g. No. 20 (	04 38400	
Physician	1. Decedent's Name (First, Middle, La					2. Date of Deat	h Dav	3. Time of Death	
/Medical Examiner	JOHN  4a. Facility Name (If not institution, given frederick Memori		TIN	4b. City, Town, or Frederi		Novembe	4c. County o	f Death	
Funeral Director	5. Social Security Number 6. 9		in yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			9. Birthplace (State or Foreign West) Virginia	
Maryland	10a. State 10b. County Maryland Frede		Oc. City, Town or Lo	cation Ijamsv	ville			10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
6 fiter death with the Mar riters was be notified inters was be notified Funeral Director	10e. Street and Number 5222 Mussetter	Road		10f. Zip Code	21754	10	U.S.A.	hat Country?	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23s or 28s-1 show aumatic event, the Medical Exercitate countries at To Be Completed by Funeral Director	11. Marital Status  1 Never Married 27 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 7 Yes 2 Nq If Yes, Give Year or Dates:	9/5 +0	Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		- American Indian, , White, etc. White	
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hyglene. i? Is marked other then "natural", or traumatic event, the Medical Exert To Be Completed by F	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, COLLETAC	uring most of wo	rkina	16b. Kind of Bus Contrac	iness/Industry tor/Builder	
yland Sould be filed Mental Hyg arked other atic event,	17. Father's Name (First, Middle, Last Ross Martin				18. Mother's Nar		Unknow	n	
i, Mar and 2 she salth and n 27 Is m er traum	19a. Informant's Name/Relationship of Martha L. Marti	.n/Wife	5222					tate, Zip Code) Land 21754	
Baltimore, Marylar permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic and more.	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Special	Removal from State (y)		ety cemete		2, 2004	Frederio	ck, Maryland	
Departiment Departiment Importing any inj	21. Signalur of Funeral Service Lice	Basta		Name and Address eeney & E 06 East C	hurch St	treet Fr	ederick	MD 21701	
Physician /Medical	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Sepsis	e death. Do not enter	er the mode of dying	j, such as cardiad	c or respiratory arre	st,	Approximate Interval Between Onset and Death Day S	
Examiner	Sequentially list conditions, if any, leading to immediate	b. Celluli Due to (or as a co	tis			-		Days	
icate be executed physician and sthe burial-transit coloral Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of):							
BOX 6 auth certif attending for use a:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy			23d. Date Monti	,	
Cords, P.O. w requires that the de been signed by the s should be detached	9 □ Unknown  Part II. Other significant conditions of the limit evidence of the limit e	9 Unknown contributing to death but n			n in Part I.			ute to the cause of death?	
al Records,  The law requires to cate has been signe, page 2 should be Completed by	Stroke, Diak	retes			13663	24a. Was an autopsy perform	24b. We prided	ere autopsy findings available or to completion of cause of atth?	
Y VITAI REC yaiclan: The law is: certificate has I director, page 2 s	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ER/Outpatien	t 3□ DOA Othe		ath (Check only one	)		
Jing Ph After th funeral	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not by	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury Work' M 1 \( \sup Y		28d. Describe how			
DIVII ppital or Ati ours after d teral Direct filled in by	4 Homicide determined	building, etc. (5	Specify)			City or Town,	State)	or Rural Route Number,	
DIVISIGE DIVISIGE To the Hospital or Attended within 24 hours after death. To the Funeral Director: completely filled in by the Medical Certificat	29a. Certifier  (Check only one)  2 Medical Exer	nysicien: To the best of miner: On the basis of exand manner stated	amination and/or inv	estigation, in my op	inion, death occu	rred at the time, dat	te and place, and	ner as stated. d due to the cause(s)  Month, Day, Year)	
27 W 20 0	· Mrc			D6:	2180			ber 28, 2004	
10	30. Name and address of person who 400 W 7th 5-	freet Fr	edevid		; Dr.	Fauzi	Rizu	i	
State Registrar	31. Date filed (More Co., page 2	32. Rédistrar's	signature /g	Spark.	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Moledina Day **Physician** Month yaralı November 15 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner City Johns Hospital Hopkins Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, Year) Sept 21, 1950 9. Birthplace (State or Foreign 1√2 M 2□ F 217-94-4414 54 Yrs. Kampala, Uganda Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore Cockeysville Maryland 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 2 Honeybee Court, Unit G United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 27 Married 1 ☐ Yes 2X No Specify: Asian Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Hotel 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Moledina Juma Bhachibai Kanji 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 10045 York Road Cockeysville, Maryland 21030 Mansur J. Moledina -brother 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State George Washington Cemetery 11/18/2004 Adelphi, Maryland 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sis seDue to (or as a consequence of): 1+057 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Acute Due to (or as a consequence of): Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 X-No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ZInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 K Natural 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide

Physician /Medical **Examiner** attending physician and for use as the burial-transit Records, P.O. Box 68760, detached signed I page 2 should been certificate

**Funeral** 

**Director** 

work

rthan "naturel", or items 23a or 28a-1 shov the Madical Exertiner must be notified at

filed within 72 hours after death

Il Hyglene.

Ith and Mental Hygis

7 Is marked other

reaumatic event,

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any nivy or other traumatic event once.

Baltimore, Maryland 21215-0036

o the Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital : After this certifical funeral director, I death. within 24 hours after deatl

To the Funeral Director:
completely filled in by the

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

Kajesh

31. Date filed (Month, Day, Year) NOV 17 2004

Gupta MD

The Johns Hopkins Hospital, 600 N. Wolfe Street 32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Tower 110

RES-000

29d. Date signed (Month, Day, Year)

November

			Flease I	State of Marylar				-	ene .	001.00
			State Ragistrar		Cei	rtificate of	Death		g. No. 2004	00100
и	Physici	an	1. Decedent's Name (First, Middle, Last)  OMAR  H	MIN	IAYAR			2. Date of Death Month NOV. 14	2004 Year	3. Time of Death 12:15 p M
)	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of Death	11,0 1 1 2 1	4c. County of Dea	
	Exami	ζ.	52 ANNA CT.				nersburg		Montgo	
	Funeral Director		219-02-03/1	7. Age (In yrs. XM 2 F 42	. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Sept. 5	9. Bir , 1962 Af	thplace (State or Foreign ountry) gnanistan
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgo		ity, Town or Lo	rsburg				10d. Inside City Limits 1 Yes 2 □ No
	or 28a-	)irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	s 23a	ral	52 Anna Ct.	10 Was Dasadast Sussia I	16 12 1	2087		acifu Vac or No-	USA 14. Race - Am	ericen Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show minportant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic svent, the Medical Examiner must be mailing at once.	Completed by Funeral Director	11. Marital Status  1 ★ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☐ No lif Yes, Give Year or Dates:		was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
2-00	72 hou	eted	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Dece	dent's Usual Occu	ipation during most of work ed)	ring 1	6b. Kind of Business	/Industry
121	within lene. then "	отрі	Elementary/Secondary (0-12)	College (1-4or 5+)		ployed	9d)		None	
Baltimore, Maryland 21215-0036	ld be filed ental Hygi ked other Ic svent, I	To Be Co	17. Father's Name (First, Middle, Last) WAH Minayar					e (First, Middle, M inayar	aiden Sumame)	
fary	2 should and M ls mar		19a. Informant's Name/Relationship (Typ						City or Town, State,	
e,	1 and Health em 27		Ali Minayar - Br	20b.	Place of Dispo	sition (Name of	Gaither:		d . 2087  Oc. Location - City or	
mor	Pages lent of nt: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)			natory or other pla lashing	ton 11/1	6/04 A	delphi,	Md.
Balti	permit. Departm Departm Importa sny inju		21. Signatur vot Juneral Service License	- Matu	4	$^2$ . Name and Addr 11 K $enne$	ess of Facility Un	iversal .W.,Wasl	II Mort n,D.C. 2	uary Inc. 0011
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or					or respiratory arre	st.	Approximate Interval Between Onset and Death
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,09/	le be executed ysician and e burial-transit	cai Exar	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
68	tificate ng phys as the	ed							-	
). Box	e death certificate I the attending physi- ted for use as the t	Physician/M	in the past 12 months?  1  Yes 2 No	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnand Other (specify)	су		23d. Date of de Month	livery Day Year
P.0	res that the de signed by the a be detached to		9 ☐ Unknown  Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause g	iven in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
rds	w requires been sign should be	ed by						1 □ Yes	2 <b>X</b> No 3 □ P	robably 4 Unknown
of Vital Records,	e la has	Completed						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
tal		0	25. Was case referred to medical				26. Place of Deal	1 Yes 2. h (Check only one		s 2 <b>∑</b> No
) { \	Physician: this certific ral director,	To B	TES ZEMNO	lospital: 1 Inpatient 2		IL 3L DOA			nce 6 Other (Spe	ocify)
ono	ding h. After fune	tion:	27. Manner of Death  1 X Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W	uryat ork? ⊒Yes 2 ⊒No	28d. Describe how	v injury occurred	
Division	il or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, sti	reet, factory, office	9	28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Atwithin 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the vestigation, in my	time, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0	۷, ۵۵،		nse number		d. Date signed (Mon	
	2		Hay	u		D35	035	N	ovember	15, 2004
			30. Name and addresslot person wholed Joseph Kaplan,				n Dr O	lnev M	d. 20832	
7	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 4	Spark		. u ⊂ y , M	4. 20032	
	Regist	rar	NOV 1 7 200	14	1	jujous	10			

DHMH 17 Rev 1/2001

			1 - State of Maryland / De State of Maryland	epartment of Health and Months		2004	38403
			Decedent's Name (First, Middle, Last)	The state of Boats	2. Date of Death		3. Time of Death
	Physici /Medic		Norbert B. Miller		November	15, 2004	1:20 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			Shady Grove Adventist Hospital	Rockville		Montgome	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth:	Months Days Hours Min	8. Date of Birth (Month, Day, Y	ear) 9. Birti	hplace (State or Foreign untry)
	Director		201-16-4543	3.	August27	,1926 M	aryland
	yland Iow		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	Man B-f sh	tor	Maryland Montgomery Mont	gomery Village			1 ☐ Yes 2X☐ No
	th the	irec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?
	ath wi	Tai	19501 Brassie Place	20886	Un	ited Stat	es
	ar deg	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs afte	y F	1 □ Never Married ¾□ Married 1 1 □ Yes 2 □ No 1946 — If Yes, Give 1949   1 □ Yes 7 □ No 1946 — If Yes, Give 1949   1 □ No 1946 — If Yes, Give 1940   1 □ No 1946 — If Yes, Give 1940   1 □ No 1946 — If Yes, Give	1 ☐ Yes 2 No Specify:		Specify: Wh	ite
21215-0036	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show dical Examiner must be notified at	edt	1747	ecedent's Usual Occupation	16	b. Kind of Business/I	
715	hin 72 In "na Media	plet	(Specify only highest grade completed)	Give kind of work done during most of work fe. DO NOT use retired)	ing		
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b	al Hy al Hy doth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
yla	Ment Ment arke	To	Walter X. Miller		Murnaugh		
Maryland	12 sh and r Ism			Mailing Address (Street and Number or Rura		-	· · · · · · · · · · · · · · · · · · ·
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examination in the instilled all once.			01 Brassie Place-Mor		village, I	
Baltimore,	ages int of t: If it		1 ☐ Burial 2 Xi Cremation 3 ☐ Removal from State cemetery,	crematory or other place) Nov Distan Crematory 200	. 16.	•	
를	artme ortan injury		'4 □ Donation 5 □ Other (Specify)  21. Signature of Funcial Service Lisensee	22. Name and Address of Facility De			Virginia
Ba	Dep imp		MAN.W.	10 E. Deer Park Dr			MD. 20877
	_		23a. Part 1. Enter the disagse, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Shock			Onset and Death
	/Medical		resulting in death)  a. Due to (or as a consequence of)		<u> </u>		12 997
Н	Examiner		Sequentially list conditions, b. QCVC	respiratory	fails	.16	1000
	ed sit	Examiner	Sequentially list conditions, if any, leading to him addition cause. Enter Underlying Cause (Disease or injury that believe whether the conditions were the conditions are the conditions are the conditions are the conditions are the conditions are the conditions are the conditions are the conditions are the conditions are the conditions are the conditions are the conditions are the conditions are the conditions.				
	xecut and al-trar	xan	that initiated events resulting in death) Last  Due to (or as a consequence of)	15 Cd - C1	11612		
8760,	The law requires that the death cartificate be axecuted ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		1/5/1/5/1	16421 av			
9	tificat ig phy as th	Physician/Medical					
Box	leath cartifica attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death	3 ☐Ectopic pregnancy		23d. Date of delivery	•
	ne deat the att hed fo	sicie	1 Yes 2 No	5 Other (specify)		Month	Day Year
P.O.	that the de ed by the detached	Phy	9 🗆 Onknown	na vadaskim savas sivas is Dad I	220 Did tohoo	co use contribute to	the serves of death?
g,	ires tha signed d be det	l by	Part II. Other significant conditions contributing to death but not resulting in the	A	1 Yes	2 0 3 Pro	
Ö	w requir been si should	Completed	CINE MIL	. ()			
Rec	he lav	du	0,000		24a. Was an autopsy performed	prior to c	topsy findings available ompletion of cause of
a		e Co	25. Was case referred to medical	OO Plant of David	1 ☐ Yes 2 ☐	No 1□Yes	200
⋚	/sicie s cert directe	0 8	examiner?  1   Yes   2   No	26. Place of Death		e 6 □Other (Spec	ih)
Division of Vital Records,	Attending Physicien: or death. actor: After this certifically the funeral director.	-	27. Manner of Death 28a. Date of Injury 28b. Tim	ne of 28c. Injury at	28d. Describe how		ny)
Ö	ttendin death. stor: Afr / the fur	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
<u>≅</u>	l or Attence after death Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,
0	oltal c urs af erel D						
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Diractor: Atter th completely filled in by the funeral	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, or and manner stated. 2 Medical Examiner: On the basis of examination and/or and manner stated.	feath occurred at the time, date and place, a or investigation, in my opinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier	29c. License number	29 <b>d</b> .	Date signed (Month	, Day, Year)
}			MINUGans	DLILIGE	1	czenh	-v152004
	341		30. Name and address of person who completed cause of death (Item 23a) (Ty			1/10	200
			1 (59 mli 19139 Doc	ter Drive C	ec-ma	intering;	17805
	Sta Registr	100	31. Date filed (Month, Day, Year) NOV 1 7 2004	Spark			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 33Time dipodan [4 Decedent's Name (First, Middle, Last) **Physician** 10:15 a M November Ĩ5, 2004 C. Miller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 14805 Pennfield Circle, Apt. 305 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 20 F Yrs. 578-46-9433 Director 86 Dec. 3, 1917 Washington, DC Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow 10a. State 10b. County 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring Direct with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a or and the representation of the contract th 14805 Pennfield Circle, Apt. 305 20906 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🙀 No Specify SpecifyWhite þ 3 X Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry The Medical 15. Decedent's Education (Specify only highest grade completed) then College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Federal Government 7 la marked other traumatic event, 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I ent: If item 27 Is marked of Alexander P. Cardno Annie McRobbie 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages remained Department of Health an Importent: If item 27 le any injury or other tre Sandra Gillette/ Daughter 18601 Shadowridge Terrace, Olney, MD 20832 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place Parklawn Memorial Park 19 November b 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any it rancis J. Collins Funeral Home Inc University Blvd, W, Silver Spring, MD 20901 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Alzheimer's Disease Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 2 ☑ No or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 ☑ No this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: After 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 T Homicide Hospital 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D15236 November 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11125 Rockville Pike, Rockville, MD 20852 Carl I. Margolis, M.D

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

**NOV 17** 2004

32. Registrar's Signature

			1- FoAmend Item 2	27 pestate of	Masyland/o	Pen Ce	Attment of Hertificate of E	ealth and Mo Death	ental Hygie	7004 No.	38405
			1. Decedent's Name (First, Midd.						2. Date of Death		3. Time of Death
	Physici /Medi		Ranaganay	akamma	Naras	i mm	achar		Month NOV.	1, 2004	3:10A M
	Examir		4a. Facility Name (If not institutio				4b. City, Town, or I	Location of Death		4c. County of Death	3.1021
			Suburban H	ospital			Bethes	sda		Montgom	nerv
	Funeral		5. Social Security Number	6. Sex 7	Age (In yrs. last bi	rthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye		place (State or Foreign
	Director		UNKNOWN	1 □ M <b>2</b> (□ F	86	Yrs.	Months Days	Hours Min.	Oct.2,1	918 Inc	lia
	pu ,		Usuel Residence of Decedent  10a, State 10b, County		40- 0'h T						
	aryla ehov	_	,	GOMERY	10c. City, Tov		sda			1	Od. Inside City Limits
	8a-f	Scto		GOMEKI	ье	CIIE					1 XYes 2 No
	vith th	ä	10e. Street and Number				10f. Zip Code		10g.	Citizen of What Cour	ntry?
	72 hours after death with the Maryland neturel', or Items 23a or 28a-f ehow diest Examiner must be matified at	Funeral Director	8202 Osage				208			India	
	er de tem	nue	11. Marital Status	12. Was Deceder Armed Force	s?	13.	Was Decedent of His f Yes, specify Cuban	spanic Origin? (Spec i, Mexican, Puerto F	cify Yes or No- tican, etc.)	14. Race - Americ Black, White,	
36	s afte	by F	1 ☐ Never Married 2 ☐ Mar 3 🗗 Widowed 4 ☐ Divorced	If Yes, Give			1 ☐ Yes 2X No	Specify:		Specify: Whi	.t.e
21215-0036	turel	be pe		Year or Date:		Dage	deetle Herrel Occurre	*:	4.01	16-1 (8	
5	n 72 1 "ne 1 adic	Completed	(Specify only highe	st grade completed)	102	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	uring most of workin	g 160	. Kind of Business/In	dustry
12	within lene. than "	m.	Elementary/Secondary (0-12)	College (1-40	r 5+)		estic			Home	
9	filed Hygid other	ပိ	17. Father's Name (First, Middle,	Last)				18. Mother's Name	(First, Middle, Mail	den Sumame) นุ ๙	<i>v</i>
Maryland	should be filed within 72 hours after death with the Marylan and Mental Hygiene. I marked other than "neturel", or Items 23a or 28a-f ehow marked other than "neturel", or Items 23a or 28a-f ehow unatic event, the Madical Examiner must be notified at	To B	Shelva Pi	lla Iyenga	a۳				kkayya	. 4.	
ary	2 shou and M is mar eumat	-	19a. Informant's Name/Relations	hin (Time Brint)		o. Mailir	ng Address (Street ar			ty or Town, State, Zip	Code)
	and 2 lith a 27 is	~	Narasimmacha	r NarasimÌ	nan 1	9 F	unning E	Fox Rd C	olumbia	, SC 292	23
Baltimore,	s 1 ar	l i	20a. Method of Disposition		20b. Place o	f Dispo	sition (Name of natory or other place,	Da	ite 20c	. Location - City or To	own, State
E	Pages nent of f ant: If ite		1 ☐ Burial 2 XCremation 1 ☐ Donation 5 ☐ Other (S		10		nrl Svcs		/2004 A	lexandri	a. VA
alti	permit. Page Department of Importent: If eny injury or once.		21 algnature of Fundal Service	Licer ee	0					neral Ho	
ä	P P P P	- 1	ROPE T	noue	del						MD20850
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the death. Do	not ent	er the mode of dying,	, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	-	MON	116					Onset and Death
	/Medical		resulting in death)		as a consequence						1 WEEK
	Examiner		Commentation that are distant	b							
-	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a consequence	of):					
	nd rans	Examin	that initiated events	с							
90,	e exe ian a urial-		resulting in death) Last	Due to (or a	is a consequence	of):					
68760,	icate be executed physician and s the burial-transit	edical		d							
		Mec	IF FEMALE:						-		
Box	ath ce	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 [	Ectopic pregnancy			23d. Date of delive	1
	at the dea by the a tached fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant 9☐Unknown	at time of death	5 [	Other (specify)			Month	Day Year
P.0	that the	Phy			h		4. 1.		00 - 0:444		
ŝ	es gn be	by	Part II. Other significant condition	TREMIA		n tne ui	ideriying cause given	п п Рап I.	1 Tes	o use contribute to th	
oro	w requir been si should	ted	19/10/17	CINE /VI/M					i Tes	2 1 NO 3 PIOD	ably 4 □Unknown
Vital Records,	e law has b	Completed							24a. Was an autopsy	prior to cor	osy findings available inpletion of cause of
H		Co							performed 1 ☐ Yes 2 🖼		212 No
/ita	Physicien: T this certificat ral director, pa	Be	25. Was case referred to medica examiner?					26. Place of Death			
of \	Physi this c	10	1 ☐ Yes 2 17 No	Hospital: 1 ☐ Inpa			t 3□ DOA Other	4 Nursing Home		6 ☐ Other (Specify	)
E C	ding P h. After I funera	on:	27. Manner of Death  XXNatural 5 ☐ Pendir	28a. Date of In (Month, D	jury 28b. 1	Time of njury	28c. Injury a Work?		ld. Describe how in	njury occurred	
Sio	Attending r death. sctor: After by the fune	cati	2 Accident investig	not be				es 2 □ No			
Division	- 0	Certification:	4 Homicide determ	ined 289. Place of I	njury - At home, fa etc. <i>(Specify)</i>	ırm, str	eet, factory, office	28	If. Location (Street City or Town, St	and Number or Rura ate)	Route Number,
	ours a		OD CONTINUE AND CONTINUE OF THE CONTINUE OF TH	- Physician T 11 - 1				1			
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifyir (Check only 2 Medical one)	ng Physician: To the bes Examiner: On the basis and manner:	of examination an	e, death	occurred at the time restigation, in my opir	, date and place, an nion, death occurred	d due to the cause I at the time, date a	o(s) and manner as stand place, and due to	ated. the cause(s)
	o the	Me	29b. Signature and title of certifie		/_		29c. License r	number	29d.	Date signed (Month, L	Day, Year)
	- s - ō		James	Work	and M	>	MADO	0556/2	3.0	sember !	2004
		1	30. Name and address of person	who completed cause of	death (1 -m 23a)	(Type			the state of the s		
			SUBURBAN HOSFI				ETOWN RO			4D 20	214
	Sta	te	31. Date filled (Month, Day, Year) DEC 0 3 2004		trar's Signature	1	als	2 2000			-11
	Registr		DEC-03 2004	1 Jonas	1	pg)	vers				

	1	State Registrar	State of M		ertificate					Reg. No.	004	3840
Physician		<ol> <li>Decedent's Name (First, Min</li> </ol>							2. Date of D	eath	, 2004	3. Time of Death 11:01 P.
/Medical		James	Rodney	•	Pende				NOVEIL			
Examiner		la. Facility Name (If not institu 18612 Maugins	Avenue		Hage	rsto				Was:		County
uneral Pirector		5. Social Security Number 215-52-1701	6. Sex 7. Ag	e (In yrs. last birthd	Months	Days	If Under Hours	Min.	8. Date of Bi Sept.	Ž2 <sup>Ye</sup> 4)94	9. Birth	place (State or Fore ntry) yland
<b>3</b>	-	Usual Residence of Decedent  10a. State 10b. Cou	ntv	10c. City, Town o	Location							10d. Inside City Lim
of S			ington	Hagers								1 ☐ Yes 2 🔯
t or 28a-f sl be notified Director	3	10e. Street and Number	Ington	nagers	10f. Zip	Code				10g. Citizer	n of What Cou	ntry?
3a or	5	18612 Maugan	s Ave.			742				U.S.A		,
that rygiants and are trans 23a or 28a-f show dothar than "natural", or trans 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	5	11. Marital Status  1 ☐ Never Married 2 🖔 N 3 ☐ Widowed 4 ☐ Divord	If Yas Give	Ever in U.S. No 1966- 1969	3. Was Decede If Yes, speci 1 \( \text{Yes} \) 2		ispanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)	0- 14.	Race - Americ Black, White,	
ygiene. nar than "natura it, the Medical B	2	15. Dece (Specify only hig	lent's Education hest grade completed)	16a. De	cedent's Usual ive kind of work b. DO NOT use	Occupa	ation during mos	t of work	ing	16b. Kind	of Business/In	ndustry
is marked other than aumetic event, the Me		Elementary/Secondary (0-1)	College (1-4or s	3+)	hanic	o roimou	,			Air	craft	
evant, le Be Co	5	17. Father's Name (First, Midd	le, Last)				18. Mothe	r's Name	e (First, Middle			
atic ev To B	3	James A. Pend	ergast				Vi	da S	Smith			
s ma uma		19a. Informant's Name/Relation	onship (Type, Print)	19b. M	ailing Address	(Street a	and Numbe	r or Run	al Route Numb	ber, City or To	own, State, Zij	Code)
Department of resent and wental important: If item 27 is marked any injury or other traumatic events in the control of the con		Patricia A. Pe	ndergast/Wife	186	12 Mau	ans	Ave.	, На	gersto	wn MD	2174	2
roth	1	20a. Method of Disposition	n 3 Removal from State	20b. Place of Di	sposition (Namerematory or other	e of			Date		ion - City or To	own, State
ry o		'4 □Donation 5 □ Other		Rest Ha	ven Cen	nete	ry  1	2/1/	2004	Hager	stown,	MD
y inju		21. Signature of Funeral Serv	ce Licensee		22. Name and	Addres	s of Facilit	y Res	st Have	n Fune	ral Ch	ane1
E & 8	1	> 5 Mark	Supp		1601 Pe	enns	ylvan	ia A	Ave. H	agerst	own. M	D 21742
sician and sician and serial-transit aminer sal Examiner		disease or condition resulting in death)  Sequentially list conditions, farty, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of):	nd of	Ne	0					
od by the attending physicial detached for use as the but the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pre 5 □ Other (spe					23d	. Date of delive Month	ery Day Year
ed yd	1	art II. Other significent conc	itions contributing to death b	ut not resulting in the	e underlying ca	use give	on in Part I.		23e. Did 1	V		ne cause of death? pably 4 Unknown
cate has been si	-								24a. Was auto perio		prior to con death?	psy findings availa mpletion of cause of
rector,		25. Was case referred to med examiner?					26. Place	of Death	(Check only	оле)		
To T	2	1 XYes 2 No	Hospital: 1 Inpatie			Othe	or. 4□ Nui	rsing Ho	me 5 Resi	dence 6 🛚	Other (Specif	At scer
Funaral Director: After a stelly filled in by the funeral dical Certification:		3X Suicide 6 ☐ Cou	stigation (124) (1	04 10:59	412W	office	?	Na	28d. Describe  SUV  28f. Location ( City or To	nect	Sho	+ Self I Route Number, Laugins A
Funar ely fill ical		29a. Certifier 1 Certification Check only cone)	ying Physician: To the best al Exeminer: On the basis of and manner sta	of my knowledge, de examination and/or	eath occurred a investigation, i	t the tim	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as st	ated. the cause(s)
To the Fun completely Medica		29b. Signature and title of cert			29c.	License	number			29d. Date si	gned (Month,	Day, Year)
- 0		· Carde	Hallan	ud		0	CME		ī	Novemb	er 25,	2004
LX	1	30. Name and address of pers	on who completed cause of d	eath (Item 23a) (Tyr	1 Penn	Str	eet,	Bal.t	cimore,	Maryl	and 21	201
0 A		31. Date filed (Month Oxy Ye	ar) 32. Registra	~								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 28 2004 2:37 AM M Nellie C. Poehlitz /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Jan. 10, 1927 9. Birthplace (State or Foreign 6. Sex **Funeral** Days 1 □ M 2 🔀 F Maryland 217-24-3959 Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Examinat must be notified at once. 1 ☐ Yes 2 No Director MD Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18912 York Road 21120 U.S.A. 12. Was Døcedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry behlitz, Nellie (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Officer Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Merle R. Beeker Laura Christine Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18214 Foreston Rd., Parkton, MD 21120 Merle Beeker, Brother 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Pine Grove United Methodist Cemetery Dec. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkton, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signar to W uner Service Licenses 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 ension to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ente Immediate Cause (Final disease or condition resulting in death) etroperi Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? I EULUOUS ON 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 🗌 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date, signed (Month, Day, Year) 12732 Charles A. Baltimore Pd. of death (Item 23a) (Type, Print) 6701 GEORGE 32. Registrar's Signature State Registrar

			For State Registrar	State of	of Marylar	•	artment of H		nd Mental Hy	gienę. Reg. No	2001.	38408	
			Decedent's Name (First, Middle	e, Last)					2. Date of De	ath		3. Time of Death	
	Physicia /Medic		Kenneth Lee	Peacock					NOVEMB	ER 26	$\frac{1}{2004}$	4:20P. M	
	Examin	er	4a. Facility Name (If not institution GREATER BALTIMO)	•		R	4b. City, Town, or TOWSO		Death		County of Death		
	Funeral Director		5. Social Security Number 218-70-8836	6. Sex <b>XX</b> M 2 ☐ F	7. Age (In yrs. 46	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da 6/25/	19, Year)	Cour	place (State or Foreign ortry) TVland	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits	
	Mary!	tor	PA Yor	k	s	tewar	tstown					1X Yes 2 No	
	r 28g	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cour	ntry?	
	th witi	al D	31 S. Main S	Street			17363			US	A		
920	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or items 23a or 28a-f show event, I'm Medical Examination must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marr  3 ☒ Widowed 4 ☐ Divorced	ied Armed F	2 ZNo ive		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes XXNo	ispanic Origin n, Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Americ Black, White, Specify: Wh	etc.	
21215-0036	in 72 ho n "natur Aedical	Completed	15. Deceden (Specify only highe	st grade completed,		16a. Dece (Give life.	dent's Usual Occup kind of work done of DO NOT use retired	ation during most o	f working	16b. Kin	nd of Business/In	dustry	
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Maryland	I be file ad oth event	Be	17. Father's Name (First, Middle, Robert B. Pe	•	Sr.				Name (First, Middle, Maiden Sumame)  Jane Derry				
Ž	should be ind Mental Is marked o	٥ ٢	19a. Informant's Name/Relations			19b Mailie	ng Address (Street		or Rural Route Numb		Town State Zir	Code	
	od 2 lith a 27 li		Brian Peacoo			ll RD, H							
ore,	ges 1 and 2 it of Health if Item 27 or other tra		20a. Method of Disposition Surial 2 ☐ Cremation	3 □ Removal from	20b. F	0) 110	Date 2/1/2004	20c. Loc	cation - City or To	own State			
Baltimore,	Pa In the land		4 □ Donation 5 □ Other (S 21. Snature of Fune 1 Service	pecity)	State Mt Me					rtuary,In			
B	permit. Departr Imports any Inja		J.X.	ariens	Zen	Stewar	tsto						
	Frrysician /Medical Examiner		23a. Part 1. Eyer the disease, or shock, of heart failure. List Immediate Cause (Final disease or condition resulting in death)	aDue to	rdiac or respiratory a		SFaso	Approximate Interval Between Onset and Death					
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	G	(or as a consec								
.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregni birth 2 Feta nant at time of c nown	I death 3	Ectopic pregnancy Other (specify)			2:	3d. Date of delive Month	ery Day Year	
<u>α</u>	res that igned b	by Pł	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying cause give	en in Part I.				ne cause of death?	
ord	w requir been si should I	ted	2 garamans le	A CACK	nonu	of Lott	Trusil		_ 10	Yes 2	No 3∏ Prob	pably 4 Unknown	
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Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medica examiner?						Death (Check only	one)		_	
of		2	Y□Yes 2□No			ER/Outpatier		4 🔲 Nursi	ng Home 5 🗌 Resi			y)	
ono		tlon:	27. Manner of Death  1	19	of Injury oth, Day Year)	28b. Time o Injury	Worl	rat <br Yes 2 □ No	28d. Describe	how injury	occurred		
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	e of Injury - At h ding, etc. (Specia		reet, factory, office		28f. Location ( City or To		l Number or Rura	Il Route Number,	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifyir (Check only one) 2 Medical	Exeminer: On the I	e best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and pointion, death	place, and due to the occurred at the time,	cause(s) a date and	and manner as s place, and due to	tated. o the cause(s)	
)	Tott withir Tott comp	Me	29b. Signature and title of certifie	morti	n hu	)	29c. Licenso	.M.E.	1		signed (Month,		
	0		30 Name and address of person	who completed cau	se of death (Itel	п 23а) (Туре,	Print) 111 Penn	Street	, Baltimon	ce, M	aryland	21201	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 3	2004	Registrar's Signa	2		4		-			
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State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** George E. Powell, Jr. 17, Nov. 2004 7:44A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Ft. Washington 6801 Bock Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 9. Birthplace (State or Foreign **™**M 2□ F 63 Yrs. Dec. 10, 1940 WashingtonDC Director 578-54-4636 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic evant. It is Medical Examinar must be notified at Yes 2□No Director Prince Georges Md. Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6801 Bock Road 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 3/ENO Specify: 2 Specify: Black 3 ☐ Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental hygiene. Important: If item 27 is marked other than "I any injury or other traumatic event. If a Mad Elementary/Secondary (0-12) College (1-4or 5+) 12 Counselor District Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George E. Powell, Sr. Malissie Dickens 19b. Mailing Address /Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daphne Powell-Wilkes (Dgtr) 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town State Murial 2 Cremation 3 Removal from State `4 ☐Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. 11/22/04 Brentwood, Md. 21. Signature of Funeral Service Licensee Ralph Williams Funeral Service 767 1813 Potomac Ave., SE; Wash., DC Willems 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final stroke Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to cr as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit certificate be executed melli Diabetes Due to (or as a consequence of): Box 68760. Physician/Medical arett IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4 Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No Division of Vital 1 Yes 2 1 NO 1 Yes tha Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Tyes 21 No this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 EV Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M 11-19-04 san H. Housen DC 9603 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan H. Houseman Pennsylvama Av. NW 2100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NUV 1 9 2004 Registrar

			1 - For State Registrar	ate of Maryland		artment rtificate			and M		jiene Jeg. No.	004	384	: 10
	Div		Decedent's Name (First, Middle, Last)							2. Date of Dea Month		Voor	3. Time of	
	Physici /Medic		Robert Alan P	addy						Novembe		2004	3:20	РМ
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П	Funeral Director		5. Social Security Number 6. Sex 1X M	7. Age (In yrs. I.	Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day 2-24-19	Year)	Cour		or Foreign
			Usual Residence of Decedent	33						Z-Z4-19	51	Mar	yland	
	nyland how		10a. State 10b. County	10c. City	, Town or Lo	cation						1	0d. Inside Ci	•
	e Ma	cto	Maryland Calvert			Lusby							1 🗆 Yes	2 X No
	ith the	Dire	10e. Street and Number			10f. Zip				1	0g. Citizen	of What Cour	ntry?	
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21	rithin se. se.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of wor DO NOT us	e retir <b>e</b> d,	)	Or WOTA	,,,9				
2	illed within 72 hours after death with the Maryland Hygiene. kther than "natural", or Items 23a or 28a-f show ent, the Medical Exentral must be notified at		8th  17. Father's Name (First, Middle, Last)		Ro	ofer		19 Mothe	de Nome	(First, Middle,		tructi	on	
anc	d d d o	Be	Norman Eldridg	e Paddy				18. MOTHE		ry Ruby				
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	S a a		Christy R. Foster/ N	·		-				_ 288 19		and 20		
more,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Nam	e of					on - City or To		
Ē	Pages nent of ant: If its ary or o		XXBurial 2 ☐ Cremation 3 ☐ Remo  4 ☐ Donation 5 ☐ Other (Specify)	vai irom State -	kemont				1–18	3-04	David	sonvil	le, MD	)
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Feneral Service Licensee			orge P. nd Rd. E								
8760,	The law requires that the death certificate be executed with the law requires that the death certificate be executed with the law requirement to be should be detached for use as the burial-transit and law requirements.	dicai Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a conse	ence of):	the mode	sm	nsuch as	-	or respiratory arr	est,	4	Approximate Interval Beh Onset and IZ MON	ween
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Division of	ding P h. After I funera	lon:	1 Natural 5 Pending	Ba. Date of Injury (Month, Day Year)	28b. Time of Injury		Work			28d. Tescribe ho	w injury occ	curred		
<u>s</u>	Nttendi death. ctor: A y the fu	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Be. Place of Injury - At hor	me form str	M		'es 2□N		28f. Location (St	mot and Mu	mhor or Pura	I Pouto Mum	ha -
2	al or Attend after death Director:	ertification;	4 ☐ Homicide determined	building, etc. (Specify,		et, ractory,	OHICE		1	City or Town		mber or nura.	r noble rvami	ber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred a	at the time in my op	e, date and inion, deat	d place, a	and due to the ca ed at the time, d	ause(s) and ate and plac	manner as st e, and due to	ated. the cause(s)	)
	To th withir To th comp	Me	29b. Signature and title of certifier	- 00		29c.	License	number		2	9d. Date sig	ned (Month, I	Day, Year)	
			Hustille	7/10		1	too	37	221	ny	11/15	104		
			30. Name and address of person who comple		23а) (Туре,	Print)					-			
			Stephen Cafferty, M.I		n Squa	re Dr	·, I	Lusby	MD	20657				
	Sta Registr		31. Date filed (Month, NOVar) 6 20	32. Reservar's Signat	K	Stock	6							
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Registrar

Baltimore, Maryland 21215-0036

			For State Registrar	State of M	aryland /	•	artment of				ne 004	38412
			Decedent's Name (First, Middle, L.)	ast)						Date of Death		3. Time of Death
	Physici /Medic		WILLIAM LEO QUAI	DΕ						Month VEMBER	13 2004	02:50A M
No.	Examin		4a. Facility Name (If not institution, g	ive street and number	r)		4b. City, Town,	or Location	n of Death		4c. County of Dea	th
		•	CALVERT MEMORIAI				PRINCE				CALVERT	
	Funeral Director		5. Social Security Number 6. 212–16–6355	Sex 7. A	nge (In yrs. last bi	irthday) Yrs.	Months Day:		9r 24 Hrs. 8. Min. J.A.	Date of Birth (Month, Day, Yo N. 1,	9. Bir C L 920 MAR	thplace (State or Foreign ountry) YLAND
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Lo	ncation			<del></del>		10d. Inside City Limits
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	72 hours after death with the Maryland neturel; or Itams 23a or 28a-f show iteal Examinar must be notified at	Funeral Director	MD CHARLES  10e. Street and Number	5	HUGHES	VIL	10f. Zip Code			10a	. Citizen of What C	ountry?
	3a or	٥	8464 LEONARDTOWN	I ROAD			2063				U. S. A	
	ms 2	Jera	11. Marital Status	12. Was Deceden		13.	Was Decedent of If Yes, specify Cu		origin? (Specify	Yes or No-	14. Race - Am	erican Indian,
9	or Ita		1 Never Married 2 X Married	Armed Forces 1 XYes 2 If Yes, Give			1 Yes, specify Cu 1 ☐ Yes 2 ☐ No			in, etc.)	Black, Whi	te, etc.
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Maryland	<b>e</b> 6 5 5	To Be	JOSEPH LANSDALE								VILLIAMS	
lan	2 she and Is m		19a. Informant's Name/Relationship				-				ity or Town, State,	
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Baltimore,	0 0		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from State	e cemete	ery, crei	sition (Name of matory or other pi		NOVEMBE	ıĸ	c. Location - City or	
ţ	t. Pa rtmen rtant:		*4 □ Donation 5 □ Other (Spec		TRINI		MEM. GRD		16, 200		VALDORF,	
Bal	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Lip	ensee the	M00641							NL.HME.,P.A. , MD 20622
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each	ed the death. Do line.	not ent	er the mode of dy	ing, such a	as cardiac or re	spiratory arrest		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. Card	19C 1	Ax	Thyth	mic	CP			5 minutes
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence		_		1	1.		
		1	Sequentially list conditions,	b. Due to (or a	70SCI en	OH	c Caro	love	esulv	1 diso	ase	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0. 0		0.,.						
	al-tra	xai	that initiated events resulting in death) Last	c Due to (or a	s a consequence	of):						
8760,	ate be executed hysician and the burial-transit	ical		d								
9	tificate g phys as the											
Вох	eath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Petal deat	h 3[	Ectopic pregnan	CV			23d. Date of de	
	deat he attr	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death		Other (specify)				Month	Day Year
P.0	at the de d by the a stached	Phy	9 Unknown								1	
Records,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions  Bilateral	Pneuma		in the u	nderlying cause g	liven in Part	t I.		2 No 3 P	robably 4 Funknown
00	w require been si should b	Completed	Compostivo	Heart		120				24a. Was an	24b. Were a	utopsy findings available
Re	The lav	duc	Find Sta		menti					autopsy	d? death?	completion of cause of
Vital		e C	25. Was case referred to medical	ge Dei	rricr) t	4.		26. Plac	ce of Death (CI	1 ☐ Yes 2 ☑	YNo 1 ☐ Yes	2 □ No
<u> </u>	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat	tient 2 ER/O	utpatier	nt 3 DOA		_		e 6 □Other (Spe	cify)
J of	ding Phy h. After thi funeral o		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of In (Month, D	jury 28b.	Time of	28c. lnj			Describe how		
jo	ttendin death. stor: Afr / the fur	atic	2 Accident investigat	ion				Yes 2	□No			
Division	or Attending Physicien: after death. Director: After this certifica in by the funeral director, i	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of I	njury - At home, f etc. <i>(Specify)</i>	arm, str	eet, factory, office	9	28f.	Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	To the Hospitel or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the	Medical Co		Physician: To the bes aminer: On the basis and manners	of examination a							
	To the within 2 To the complet	Me	29b. Signature and title of certifier					nse number			Date signed (Mont	
			Cycu	C-M	rana	4	D	506	553		11-13.	2004
5	REEL		30. Name and address of person wh	o completed cause of			Print) GYI	7N	. C. S	URAN	)A >. 207	5-1
4	Sta	ite	31. Date filed (Month, Day, Year)		trar's Signature			- Lake	care	111/2	- 401	- 1
ja.	Registi		NOV 1 7	2004	em &	A	and o					

			For State Registrar	State of Man		artment of H			2006	38413
			Registrar  1. Decedent's Name (First, Middle, Las	t)	Ce	runcate or i	Dealli	Re 2. Date of Death	9.110.	3. Time of Death
	Physici	an		llen Robert	S			November	Day Yeer	6:00 PM <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Deat		4c. County of Dea	
	Examili	ं	Citizens Nursin			Frede			Freder	ick
	Funeral		5. Social Security Number 6. Se	7. Age (/	n yrs. last birthday)			8. Date of Birth	9 Rir	thplace (State or Foreign
0	Director		377-24-0100	□M 2021F 92	Yrs.	Worth's Days	Tiodis William	Feb. 10	, 1912 Wa	shington, DC
	and **		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Manyl f sho	ŏ	Maryland Frederi	ck	Frederic	ck				1∭Yes 2 ☐ No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	Lountry?
	72 hours after death with the Maryland naturel; or Heme 23a or 28a-f ehow Jisal Exan, ar ment be notified at	al D	1900 Rosemont	Avenue		2170	2		U.S.A.	
	deat	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Decedent of H	ispanic Origin? (S	Specify Yes or No-	14. Race - Ame Black, Whit	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 📉 No	Specify:	,,	Specify: W	
8	hour turel	ed b	3 X Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occup	ation	-	6b. Kind of Business	
75	n na	plet	(Specify only highest gra-	de completed)	(Give	kind of work done of DO NOT use retired	durina most of wo	rking	ob. Kind of business	moustry
212	d within giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	I	Homemaker			Own Ho	ome
b	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "naturel", or Iteme 23a or 28a-f ehow event, the Medical Examinational Le notified at	Bec	17. Father's Name (First, Middle, Last)	avier Kraus				me (First, Middle, M		
yla		Tol					E11			
Maryland 21215-0036	d 2 s th ar 17 is trau		19a. Informant's Name/Relationship (7 Rodney G. Wilke	урө, Print) s, son-in-l	aw 122 N	ng Address (Street and No. James to	own Rd.,	Moon Tow	City or Town, State, . nship, PA	Zip Code) 15108
	es 1 an of Heal fitem 2 r other		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place	(e)	Date 2	0c. Location - City or	Town, State
E	Pag ent int: I		1 ☐ Surial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Mount Oli	vet Cemeter	y Dec. 4	, 2004 I	rederick,	Maryland
Baltimore,	permit. Pa Departmen Importent: eny injury once.		21. Signature of Funeral Service Licen	n	00255	2. Name and Address Keeney at	ss of Facility nd Basfo	rd PA Fun	eral Home erick, MD	
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	4	e death. Do not en	106 East	Church :	St., Fred	erick, MD	21701 Approximate
			shock, or heart failure. List only of Immediate Cause (Final	one caus, on each line.		4	2 -1	,	,	Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death)	a. Due to (or as a c	onsequence of:	en de	asenel			dys
В	Examiner				ondoquanisa oi).					V
	7.7. =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a c	onsequence of):					
VI	acuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
60,	cate be executed obysician and the burial-transit	E E	Todaking in doday/ Edot	Due to (or as a c	onsequence or):					
ecords, P.O. Box 68760, 💸	physicate sthe	edical		d.						-
×	leath certifical attending phy I for use as th	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Date of de	iverv
ğ	death a atter d for u	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim		□Ectopic pregnancy □ Other (s <i>pecify</i> )			Month	Day Year
0	that the dened by the a	hys	9 Unknow	9□ Unknown				*		
S, F	es tha igned be de	by P	Part II. Other significant conditions of	entributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord	w requir been si should							1 🗆 Yes	3 PI	obably 4 Dunknown
Records,	has by	Completed						24a. Was an autopsy	prior to	topsy findings available completion of cause of
a F	Th ate pag							perform 1 Yes 2		21 No
Vital	5 8 9	o Be	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpatier	Cthe		ath (Check only one		
of		-	27. Manper of Peath	1 ☐ Inpatient  28a. Date of Injury (Month, Day Y		f 28c. Injury	at	28d. Describe how	nce 6 Other (Spe v injury occurred	city)
<u>io</u>	Attending death. ctor: Afte y the fun	atio	1 Matural 5 Pending 2 Accident investigation	(Month, Day 1	e <i>ar)</i> Injury	M 1 [	K? Yes 2 □ No			
Division	of or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (-	- At home, farm, str	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
	itel o irs aft rel Di	Cer		li e			h	1		
	To the Hospitel or Attu within 24 hours after de To the Funerel Directo completely filled in by th	edical	29a. Certifier (Check only one) Cartifying Ph. Madical Exam	sician: To the best of n iner: On the basis of ex and manner stated	amination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occi	e, and due to the cau urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	2/2/		29c. License	e number	29	d. Date signed (Mont	h, Day, Year)
)			> Xrlull L-	Jospher		9-	1397	/	November	
	1		30 Name and address of person who	completed cause of deat	h (Item 23a) (Type,		19	<_L	Freder	ck, Md.
	7	to	31. Date filed (Morth Fall), Water	32. Registrar's		300 W	IU, NT	1 31 3	11701	
	Sta Registr		DED 0.2 5(	104 Sener		1				
						The state of the s	7.3			

•		1	For State Registrar		State	of Maryla	and / Depa	artment			and Mo		giene Rog. N&2	04	38414
	Physicia /Medic	ın	1. Decedent's Name	(First, Middle,	Last)	F	Ruffo					2. Date of Dea Month Nov 22	Day	Year	3. Time of Death 7:55 am M
}	Examin		4a. Facility Name (If I	ot institution,						Location o	of Death			ity of Deat	h
			Frostburg					Frost If Under	•		24 Hrs		Alleg		
l.	Funeral Director		5. Social Security Nur  212-12-89  Usual Residence of D	989	6. Sex 1 □ M 2 □ F	7. Age (In yr	rs. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Sep 27	, 1912	9. Birt Co	hplace (State or Foreign
	land ow	-		10b. County		10c. (	City, Town or Lo								10d. Inside City Limits
	e-fsh	ctor	MD	Alleg	any		Frost	burg							1 ☐ Yes 🎗 ☐ No
	ith the	Funeral Director	10e. Street and Numl					10f. Zip		1500			10g. Citizen o		untry?
	sath w	eral	100 Hone	ysuckl		ot. G6 cedent Ever in	119 12	Was Doord		21532		offy Vee or No-		SA	rican Indian,
(0	riter d	Fun	1 Never Marrie	d 2 Marrie	Armed F	orces?	I .					cify Yes or No- Rican, etc.)		ack, White	e, etc.
93	72 hours after death with the Maryland netural, or items 23e or 28e-f show dital Examinat must be notified at	dby	3 <b>X</b> Widowed 4	Divorced	If Yes, G Year or	2 □ No ive <b>X</b> Dates:		1 ☐ Yes 2	21LI NO	Specify:			Spec	<sup>ify:</sup> whi	te
15-(	"netu	lete		5. Decedent' only highes	s Education t grade completed	)	(Give	dent's Usua kind of wor DO NOT us	k doné d	during most	t of workin	ng	16b. Kind of	Business/	Industry
21215-0036	filed within Hygiene. Ither than "	Completed	Elementary/Second		College	(1-4or 5+)	seams		0.0100	7			Michae	l Berr	owitz Co.
g	e filed al Hyg I othe vent,	BeC	17. Father's Name (F	irst, Middle, L			, <del></del>					(First, Middle,			
Maryland	should be and Mental smarked o	스			mesburg							(McVeig			_ <del></del>
Mar	d 2 th a tre		David Eng			ephew		O The			er or Hurai	Route Number Hager	stown	n, State, 2	D 21742
ē,	es 1 and of Health of item 27 r other tr		20a. Method of Dispo	sition		20b	. Place of Dispo cemetery, cre	osition (Nam	ne of ther plac	ea)	Da	ate	20c. Location	- City or	Town, State
imo		1	1 XBurial 2 L 1 Donation 5		3 □Removal from pecify)		nion Cem			,	1	1/26/2004	Meyer	sdale	e PA
Baltimore,	permit. Pag Department Importent: I any injury o once.		21. Signature Fun	eral Service L	icensee A	nll	Mi 2	2. Name and SCS 108				ne, PA Cumber	land MD	2150	2
			23a. Rarti, Enjer the shock, or heart	disease, or failure. List of	complications that	caused the de	eath. Do not en	ter the mode	e of dyin	g, such as	cardiac or	r respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (F disease or condition		_a In	reta	ble C	mari	Zin	u He.	aut	Faile	w		Onset and Death
	/Medical Examiner		resulting in death)		Due to	(or as a cons	sequence of):	,							
		Jer	Sequentially list conditions, leading to immicause. Enter Underlicause (Disease or in	ditions, rediate	b. Due to	(or as a cons	equance oi).								
V.V	ransit	Examiner	that initiated events		c										
8760,	ate be executed hysician and the burial-transit		resulting in death) La	isi	Due to	o (or as a cons	sequence of):								
289	ficate physics the t	Physiclan/Medical			d										
ŏ	death certifica attending ph for use as t	In/Me	IF FEMALE: 23b. Was decedent			utcome of preg		⊒Ectopic pro	oonano.					ate of deli	*
Э. В	Attending Physicien: The law requires that the death certificate or death.  octor: Atter this certificate has been signed by the attending phys the funeral director, page 2 should be detached for use as the	sicle	in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown			nant at time o		Other (spe					N	Month	Day Year
P.0	res that the de signed by the a be detached t	Phy	Part II. Other signific	ant conditio	ns contributing to	death but not r	resulting in the u	Inderlying ca	ause give	en in Part I.		23e. Did to	obacco use co	ntribute to	the cause of death?
Records,	juires n sign	d by	C	Rem	ria							1 🗆 Y	′es 2□No	3 🗆 Pr	obably 4 Unknown
SCO	aw requir is been si 2 should	Completed	a	rest	ès eli	olan	1 h	at (v	Re	ar		24a. Was		. Were au	stopsy findings available completion of cause of
<u> </u>	The lay ate has page 2	Com					7					perfor	rmed? 2 No	death?	
Vital	icien: Th certificate rector, pag	Be	25. Was case referre		Hospital:				Oth		of Death	(Check only o	ne)		
of	Physical this caral direction	2	1 Yes 2 N	lo	1 1		ER/Outpatie		The second second	4 F NU		ne 5 🗆 Resid			cify)
0	ding f th. : After s funera	tlon	1 ☑ Natural 2 ☐ Accident	5 Pending		of Injury nth, Day Year)	) Injury	м	8c. Injury Work	k?ີ Yes 2.⊟I			,,		
Division	r Attendi er death. rector: A by the fu	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could n determi	ned 286. Plac	ce of Injury - At	t home, farm, st	reet, factory	, office		2	8f. Location (S City or Ton		nber or Ru	ural Route Number,
۵	urs afte										1		,		
	To the Hospitel or Attending Physicien: The within 24 burs after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only 2 one)	Certifyin	g Physician: To the Examiner: On the and ma	ne best of my k basis of exami nner stated.	knowledge, deal ination and/or in	vestigation,	in my o	pinion, dea	d place, a th occurre	ed at the time.	date and place	and due	to the cause(s)
	To t To t	2	29b. Signature and t	tle of certifier	n			290	License	e number	C		29d. Date sign	ned (Monti	h, Day, Year)
,			30. Name and addre	se of porces	who completed as	is of death /li	(A) 2321 /Tuna	Print)	7 4	0 7	8		IVon	emp	4 2, 2004
	4		30. Name and addre	NINA	CHA	NG, 14	× (07	5//	ew?	Heory	ex Cr	eels S	in fr	ort le	ing Plangland
	Sta Registr			CO3		Registrar's Sig	A A	Soc	alla						0-100
									-						

		1_ State	epartment of Health and Mer Sertificate of Death	21114 38415
		Registrar  1. Decedent's Name (First, Middle, Last)		Reg. No.  Date of Death  3. Time of Death
Physic /Med		Roberta Rose	No	OV 26, 2004 Year 21:40 M
Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		13100 Bowling Street	Cumberland	Allegany
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	(ay) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day, Year)  an 16, 1940  9. Birthplace (State or Foreign Country) MD
	-	Usual Residence of Decedent		an 16, 1940   MD
arylan show	-	10a. State   10b. County   10c. City, Town of Cur	r Location nberland	10d. Inside City Limits
he Ma	ecto	10e. Street and Number	10f. Zip Code	1 ☐ Yes 2 ☐ No
With 3e or	Funeral Director	13100 Bowling St	21502	USA
death	nera		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	
or Ite		1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:	
hours tural,	Completed by	3 Wildowed 4 Novorced Year or Dates:	ecedent's Usual Occupation	Specify: white
nin 72	plet	(Specify only highest grade completed)  (Secondary (0-12) College (1-4or 5+)	live kind of work done during most of working le. DO NOT use retired)	Too. Nind of business/industry
d will yield will be the	Com	12 Hom	emaker	Own Home
at y idition Z I Z I 3-0030 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23e or 28e-f show matter event, the M-vical Exchiner in at the notified at	Be	17. Father's Name (First, Middle, Last)	,	irst, Middle, Maiden Surname)
hould d Mer marke	2	unknown  19a. Informant's Name/Relationship (Type, Print)  19b. N	Stella Da	
Md 2 sullth an 27 ls in traus				Cumberland MD 21502
as 1 au of Hea	-	comoton;	sposition (Name of Date crematory or other place)	20c. Location - City or Town, State
Page ment ent: If ury o		1 ØBurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	Memorial Gardens 12/	1/2004 LaVale MD
Dattilliore, Inicity in the Marylan Process of the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural, or Items 23e or 28a-f show any injury or other traumatto event, the Modes Example 1 and	i	21. Signature of Funeral Service Licensee	Scarpelli Funeral Home	e, P.A.
		23a. Part 1. Inter the disease, or complications wat caused the death. Do not	108 Virginia Avenue; C	
Physiciar		23a. Part1. Inter the disease, or complications that caused the death. Do not shock or heart failure. List only one cause on each line.  Immediate ause (Final		Interval Between Onset and Death
/Medica		disease or condition resulting in death)  ARTERIOSCLEROTI  Due to (or as a consequence of)		
Examine		Sequentially list conditions b.		
pe jis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
xecut and	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of)		
icate be executed physician and sthe burial-transif	dicat	d		
rtificat ng phy as th	a	I F FOUND C		11.
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 □Ectopic pregnancy	23d. Date of delivery  Month Day Year
the a	yslcl	1  Yes 25 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)	World Say You
thaf if		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
w requires to been signs should be	d by	BORDERLINE DIABETES MELLITUS		1 Yes 2 No 3 Probably Unknown
law requir	Completed	HYPERLIPIDEMIA		24a. Was an 24b. Were autopsy findings available
The lav	mo:			autopsy performed? performed? death?  1
yaician: The is certificate hidirector, page	Be (	25. Was case referred to medical examiner?	26. Place of Death (Ch	heck only one)
Physic this c	2	1		5 ☐ Residence 6 ☐ Other (Specify)  Describe how injury occurred
tending Ph feath. tor: After th	tlon	1 Section 1 Seattle of Death 1 Section 2 (Month, Day Year) Inju	e of 28c. Injury at 28d. ry Work? M 1 ☐ Yes 2 ☐ No	, rescribe now injury occurred
Atten r deal ector: by the	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm	, street, factory, office 28f.	Location (Street and Number or Rural Route Number,
s after al Dire	Certification:	4 Homicide building, etc. (Specify)		City or Town, State)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificion completely filled in by the funeral director.	edical	29a. Certifier (Check only (Ch	eath occurred at the time, date and place, and r investigation, in my opinion, death occurred a	due to the cause(s) and manner as stated. It the time, date and place, and due to the cause(s)
o the ithin 2 o the	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
⊢≯Fŏ		V (/a 0 /) -	D09157	11-27-04
4		30. Name and address of person who complete cause of death (Item 23a) (Ty		110110
1,		Paul Snow M.D. 124	W. 3rd Street Cumberla	and MD 21502
S Regis	tate	31. Date filed (Month EC Year) 3 2004 32. Regularar's Signature	& sports	
negis	avel .	,	• •	

State of Maryland / Department of Health and Mental Hygiene [] [] 4

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For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:45P M Patricia Jeanette Rozell November 17, 2004 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Berlin Atlantic General Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Min. 1 ☐ M 2 😿 F May 24, 1937 MD 67 Director 216-34-4306 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b, County or 28a-f show 1 XYes 2 No Director Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21811 US 403 William St. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 □ Divorced Year or Dates: natural Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be Robert Ward Gosnell Anna Cecelia Lamont 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Berlin, Md. 21811 403 William St., Patty Glenn (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cape Henlopen Crematory 4 □ Donation 5 □ Other (Specify) Nov.18, 2004 Frankford, DE 21. Signal re f 22. Name and Address of Facility The Burbage Funeral Home William St., Berlin, Md. 21811 which 23a. Part. Enter the disease, or complications that of sed the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or heart failure. List only one cause on fear him. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): 68760 Physiclan/Medical IF FEMALE 00 Box 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown o 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tyes 2-12 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 5 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25 No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 17 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deall To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide ō \*\* Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 30. Name and address of who completed 31. Date filed (Month, Day, Year) State 18 Registrar

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Patricia

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		For State Registrar		State o	f Maryla		artment o			Mental Hyg	jiene <sub>eg. No.</sub> 2 (	004	38	4
Physicia /Medic		1. Decedent's Name (Firs Rosa L. Re		)						2. Date of Dea Month NOV	Day	) 004	3. Time of 0	Death PM
Examin		4a. Facility Name (If not in 24 Decatur 5. Social Security Number	Street	-		s. last birthday)	4b. City, Tov Ber	in	on of Death	8. Date of Birth	4c. County of Deeth  Worcester			Cassia
Funeral Director		209–26–2687 Usuel Residence of Dece	1[	x ]M 2⊠F	100	Yrs.	Months D	ays Hou		Feb 19,	, Year)		lece (State or try) /A	roreig
ms 23a or 28a-1 show	Director	MD W	orceste	er		City, Town or Lo					10d. Inside City Limits 1 \overline{\text{Q}} Yes 2 \subseteq No  10g. Citizen of What Country?			
23a or 2 all ban	ai Dir	10e. Street and Number 24 Decatur S	Street				10f. Zip Co				U.S.		itry?	
al', or ite	by Funeral	11. Marital Status  1 ☐ Never Married 2  3 ☑ Widowed 4 ☐ D		12. Was Dec Armed Fo 1 Tyes If Yes, Gir Year or D	2 <mark>≹</mark> Š No ve		Was Decedent f Yes, specify			ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black			
e. An "natur Medical E	Completed	15. D (Specify onl Elementary/Secondary	Decedent's Edu ly highest grad (0-12)	ication le completed) College (	1-4or 5+)	16a. Dece (Give life.	lent's Usual O kind of work o DO NOT use r	ccupation one during i stired)	nost of work	ing	16b. Kind of B	usiness/Inc	dustry	
Aental Hygienerked other that	Be	17. Father's Name (First,		2			House		other's Nam	Private Families ne (First, Middle, Maiden Sumame)				
9 2 0	T <sub>o</sub>	John O'Neil  19a. Informant's Name/R	telationship (T)	rpe, Print)		19b. Mailir	g Address (Si			na O'Nei al Route Numbel		, State, Zip	Code)	_
it of Health and M		Evelyn Johns 20a. Method of Dispositio 1 🖫 Burial 2 🗆 Crei	п	-	20b	24 D	sition (Name o	of		n, MD 21	811 20c. Location	· City or To	wn, State	
Department of Important: If Its any injury or o		° 4 □ Donation 5 □ 0	Other (Specify)	600	Re		Name and A Lewis N	ddress of Fa	son Fu	neral H	West C		r, PA	
nysician Medical		23a. Part1. Enter the disc shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	ease, or comp ire. List only o	TE/	each line.	LOVAS				or respiratory arr		001	Approximate Interval Betw Onset and Di	een
attending physicien and for use as the burial-transit	cai Examiner	Sequentially list condition that is the sequential of the sequence of the sequ		b. — Due to	Due to (or as a consequence of):  Due to (or as a consequence of):									
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igned be det	by P	Part II. Other significant	conditions co	ntributing to d	eath but not re	esulting in the u	nderlying caus	e given in P	art I.	23e. Did tol	bacco use con		e cause of de ably 4 □Ur	
ate has b	Completed									24a. Was a autops perform	ned?	Were autor prior to con death? 1 \( \text{Yes}	osy findings a npletion of car 2 No	vailat use c
fter this c	ation: To Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☐ No 27. Manne eath 1 atural 5 ☐ 2 ☐ Accident		28a. Date		ER/Outpatier 28b. Time of Injury	28c.	Othor	Nursing Ho	h (Check only on ome 5 heside 28d. Describe he	ence 6 🗆 Oth		*)	
within 24 hours after death.  To the Funeral Director: A completely filled in by the fr.	Certification:		Could not be determined	28e. Place build	of Injury - At ing, etc. <i>(Spe</i>	home, farm, str	eet, factory, of	fice		28f. Location (St City or Town		oer or Rural	Route Numb	Θ <i>r</i> ,
within 24 hours after To the Funeral Dir completely filled in	edicai		,	sician: To the on the b and man	a best of my k asis of exami ner stated.	nowledge, death nation and/or in				and due to the cred at the time, d				
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		30. Name and address of		ompleted cau	0 -	4 3				da, Edwi	D 21	81		
Sta Registra		31. Date filed (Month, Da	0V 16	2004 32. F	Registrar's Sig	nature	9 St	ocks	/					

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	Physici	an	1. Decedent's Name (First, Middle, Last		Cr			2. Date of Deat Month NOV.	Day Ye	3:Tilwe öf#Delth U	
	/Medio		Glenville R.  4a. Facility Name (If not institution, give		, 51.	4b. City. Town, o	r Location of Deat		13, 200 4c. County of E		
	Examir	er	North Arundel		1		Burnie			Arundel	
	Funeral Director		5. Social Security Number 6. Se		(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Jun. 1,	Year) 9.	Birthplace (State or Foreign Country) WV	
	/land		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
	Man 9-f sh	tor	MD Anne Ar	undel	Seve	erna Park				1 ☐ Yes 2 🙀 No	
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?	
	ath w	rail	177 Ritchie Hwy.				146		USA		
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other then "natural", or Items 23s or 28e-1 show other treumatic event, If a Madical Examinar mant be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 反 Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		pecify Yes or No- to Rican, etc.)		American Indian, White, etc. White	
21215-0036	n "natur Nedical	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	rking	16b. Kind of Busin	ess/Industry	
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yla	2 should be f and Mental I is marked of eumatic eve	To	Harry Richards	0:4				Johnson			
<u>B</u>	d 2 st th and 17 is n treum		19a. Informant's Name/Relationship (T) Mary Richards/Wife			ng Address <i>(Street:</i> 77 <b>Ritchi</b>			City or Town, Sta. Park, MD		
<u>a</u>	s 1 and 2 f Health tem 27 i		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Telephone	Date	20c. Location - City		
altimore,	Page ient of nt: if i		1 ☐ Burial 2 【XCremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)			matory`or other plac rematory	INOV	. 18, 004	Baltimo	re. MD	
Balti	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		21. Signature of Fune all Service Licens	ee 100	22	Name and Address Barranco 495 Gov.	ss of Facility			k Funeral Home k, MD 21146	
	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	he death. Do not en	ter the mode of dyin		or respiratory arre	est,	Approximate Interval Between Onset and Death	
,0928	examine be executed and and and purial-transit the burial-transit	dical Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
P.O. Box 6	that the death certificated by the attending placed for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at till 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of delivery  Month Day Year		
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ita		BeC	25. Was case referred to medical examiner?				26. Place of Dea	1 ☐ Yes 2 th (Check only one		165 2 100	
Division of Vital Records,	ting Pt After th funeral	ပို	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 Inpatient 28a. Date of Injury (Month, Day)	28b. Time o	f 28c. Injury Work	4   Nursing n	ome 5 Reside 28d. Describe ho	nce 6 Other (S w injury occurred	Specify)	
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	To the Hospitei or At within 24 hours after d To the Funerei Direct completely filled in by	edical (	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	h occurred at the tim vestigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manne ite and place, and	r as stated. due to the cause(s)	
	To the within To the Comp	M	29b. Signature and title of certifier	nua		29c. License		29	d. Date signed (M	onth, Day, Year)	
			<b>)</b>	ury	NO.	I	22108		11/1	5/2004	
			30. Name and address of person who co			*	UD	21061	Michael D	i MD	
	Sta	te.	7845 Oakwooll 1	32. Pegistrar	s Signature,	hade	الله الله	21061	Michael Do	wning Mu	
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State of Maryland / Department of Health and Mental Hygien 38419 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 4a. Facility Name (If not institution, give street and number) terre PS admac 3004 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 7/30/1933 If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**X** M 2□ F Director 218-34-1119 71 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28e-1 show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD. Harford Monkton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4032 Old York Road 21111 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: KOYES. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural, or Iten any injury or other treumetic event, the Medical Examinat once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Milk Testing Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Smith Marie Sterrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mae Ruth Sterrett /Wife 4032 Old York Rd. Monkton, Md. 21111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/29 1 ABurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Union Chapel Cem. Monkton, Maryland 22. Name and Address of Facility Jarrettsville, Maryland 21. Signature of Funeral Service Licensee Kurtz & Son Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tigle. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonara **Physician** disease or condition resulting in death) 30 minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 90 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2□ No 1 ☐ Yes 3 NO 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2XNO Other: 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral c Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending within 24 hours after death. To the Funerel Director: A М 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai npletely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (exander COON 31. Date filed (Month, Day, Year)
DEC 0 3 32. Registrar's Signature State 2004 Registrar

nysici		1. Decedent's Name (First, Middle, La	st)	39,01711/05dhb Certificate of Deat	2. Date of De Month	_	3. Time of Dear
Medic		ANNA	SELBY		OCT.	18 2004	
amir		4a. Facility Name (If not institution, giv	street and number)	4b. City, Town, or Locatio	n of Death	4c. County of De	ath
		ATLANTIC GENERA  5. Social Security Number 6. S	· · · · · · · · · · · · · · · · · · ·	BERLIN st birthday) If Under 1 Year If Und	er 24 Hrs. 8 Date of Bir	WORCES	
eral ctor			ex	Yrs. Months Days Hours		ay, Year)	rthplace (State or For country) ELAWARE
		10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Lin
	ctor	MARYLAND WORCEST	ER B	ERLIN			1 □ Yes 2
	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?
	Funeral	11736 GUM POINT		21811		USA	
	-un-	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 □Yes 2 No	. 13. Was Decedent of Hispanic ( If Yes, specify Cuban, Mexic	Origin? (Sp <i>ec</i> ify Yes or No an, Puerto Rican, etc.)	14. Race - Am Black, Wh	
	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specif	<b>'</b> y:	Specify: W	HITE
	Completed	15. Decedent's Ed		16a. Decedent's Usual Occupation		16b. Kind of Business	s/Industry
	nple	(Specify only highest gra	College (1-4or 5+)	(Give kind of work done during me life. DO NOT use retired)			
		11		OWNER & OPERATOR		RETAIL	
	Be	17. Father's Name (First, Middle, Last)	MODDIA		her's Name (First, Middle,		
	5	ARMWELL	MORRIS		ARRIE	MCCABE	
	1 3	19a. Informant's Name/Relationship	· .	19b. Mailing Address (Street and Num			
Į		BIRDIE S. POWELI		11736 GUM POINT R	Date	MARYLAND  20c. Location - City or	
		1 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specific	Removal from State	metery, crematory or other place)			
ei		21. Signature of Funeral Service Licen		HOPVILLE CEMETERY   22. Name and Address of Fac	10/21/04	BISHOPVILL	E, MARYLA
once.		94. 6. B	" and MO13	47 HASTINGS FUNER	,	BYVILLE D	F 10075
		23a. Part1. Enter the dil ease, or com	olic to no that caused the death.	Do not enter the mode of dying, such a			Approximate
an		shock, or heart failure. List only	one cause of each line.	ma. C.11.			Onset and Deat
al		disease or condition resulting in death)	Due to (or as a conseque	one of:	-		
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Ī	clar	in the past 12 nigoths?	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	eath 3 Ectopic pregnancy		23d. Date of de Month	Day Year
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	by Pi	Part II. Other significant conditions of	entributing to death but not result	ing in the underlying cause given in Part	I. 23e. Did to	obacco use contribute to	the cause of death
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	ompleted				24a. Was a	an 24b. Were au	itopsy findings avail
	mo				autop perfor	med? prior to death?	completion of cause
	O	25. Was case referred to medical		26 Plac	1 ☐ Yes	~	2 No
	0	examiner?	Hospital: 12 Inpatient 2 E	Other	lursing Home 5 Resid		cifu)
		1 ☐ Yes 2 🔀 No	29a Data of Jaium	8b. Time of 28c. Injury at Work?		ow injury occurred	ony)
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	: To Be	27. Manner of Death  1 Statural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  27. Certifying Ph	(Month, Day Year)  28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	City or Tow nd place, and due to the c ath occurred at the time, c	m, State) cause(s) and manner as date and place, and due	stated. to the cause(s)
	edical Certification: To Be	27. Manner of Death    Swiatural   5   Pending investigation	(Month, Day Year)  28e. Place of Injury - At hom building, etc. (Specify)  (sician: To the best of my knowliner: On the basis of examination	e, farm, street, factory, office edge, death occurred at the time, date a n and/or investigation, in my opinion, de	City or Tow nd place, and due to the c ath occurred at the time, c	ause(s) and manner as date and place, and due and place, and due and place and due and bate signed (Monte and august 1991).	stated. to the cause(s)
	edical Certification: To Be	27. Manner of Death    Swiatural   5   Pending investigation	(Month, Day Year)  28e. Place of Injury - At hom building, etc. (Specify)  resician: To the best of my knowl iner: On the basis of examinatio and manner stated.	e, farm, street, factory, office edge, death occurred at the time, date a n and/or investigation, in my opinion, de	City or Tow nd place, and due to the c ath occurred at the time, c	ause(s) and manner as date and place, and due and place, and due and place and due and bate signed (Monte and august 1991).	stated. to the cause(s)

0119/04 1040

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** → omers 2004 15 OSEMBEN /Medical James 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Veninsula Regional Wicomico Medical Center alisbury 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1**⊠**M 2□F Months 9 218-16-5594 Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or Itams 23a or 28e-f show ury or other traumatic event, the Medical Exam as must be notified at MD 1 ( es 2 □ No **Funeral Director** OMERSET 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 210 21817 Jomes 12. Was Decedent Ever in U.S. Armed Forces? 1 ₱ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Completed by Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Baltimore, Maryland 2121 College (1-4or 5+) Side Street Market Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maggie Ennals

19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Parker (TEORGE 19a. Informant's Name/Relationship (Type, Print) Crisfield MD 21817
ate 20c. Location - City or Town, State 210 Somers wife HElen JUMES -Cove 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Surial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. Macyland Veterars Com. 11-22-4 Hurlock, 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Home Anithony E. Ward Funeral Home 30639 Hampdon Ave. Princess Anne, 21. Signature of Funeral Service Licensee Cars 511 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician words minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated asserts. Due to (or as a consequence of): Examiner and Il-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 PNo 24a. Was an 1 ☐ Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Umpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature a

Jeffrey H.

NOV 1

31. Date filed (Month, Day, Year)

Thomas 91-818

ho

SALISBURY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2004

Etherton

32. Registar's Signature

			1 - For Stete Registrar	State of I	Maryland		artment of H		and M		giene		384	22
	Physici		1. Decedent's Name (First, Middle, Richard H. Stoh	*						2. Date of De. Month	Day		3. Time of 1:05	
	/Medio Examin		4a. Facility Name (If not institution, 5600 Wisconsin	give street and numb			4b. City, Town, or Chevy Cha		of Death	Nov. 1	4c.	2004 County of De ontgome	eath	
	Funeral Director		5. Social Security Number 213 • 24 • 3557  Usual Residence of Decedent	5. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. la 75	ast birthday) Yrs.	If Under 1 Year Months Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Nov • 24	y, Year) ,192	9. B Wa	Birthplace (State of Country)	or Foreign
	e-f show	ctor	10a. State 10b. County  FL		10c. City Nap	, Town or Lo	cation						10d. Inside Ci 1 X Yes	-
	with th	i Director	10e. Street and Number 4151 Gulf Shore	Blud Nor	th Ant	1402	10f. Zip Code 34103				10g. Citiz	zen of What	Country?	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show any Injury or other traumatic event, I'm Medical Exertication at Lemoilled 21 once.	d by Funerai	11. Marital Status  1 □ Never Married 2 ▼ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force d 1 🔀 Yes 2	ent Ever in U.S	3. 13.	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 1 No	ispanic Origin, Mexican	gin? (Spe , Puerto l	ecify Yes or No- Rican, etc.)	. 1		•	
Maryland 21215-0036	ed within 72 h /giene. ier then "natu t, ire Medica.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-40	or 5+)	(Give life. l	dent's Usual Occupa kind of work done o DO NOT use retired rman/Owne	during most I)	of working Auto:			nd of Business/Industry Dmobile Lership		
land	ild be filk lental Hy ked oth ic even	To Be	17. Father's Name (First, Middle, La Edwin L. Stohlm	•						(First, Middle, Karney	Maiden .	Sumame)		
Mary	d 2 shou th and M 7 is mar traumat	-	19a. Informant's Name/Relationshi Marianne Stohlm				ng Address (Street a	and Numbe	r or Rura	l Route Numbe				15
Baltimore,	Pages 1 and nent of Healt out: If item 2 ury or other		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	B □Removal from Sta	ite Ce	ace of Dispo	sition (Name of natory or other place	θ)	D	ate 5,2004	20c. Loc	cation - City o	or Town, State	
Balt	permit. Departr Importe any inji		21. Signature of Funeral Service Li	Est.	_ >		Name and Addres							016
	Physician /Medical		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	Metast	tatic G	Do not ent							Approximate Interval Betwoonset and E years	e ween Death
	Examiner	Iner	Due to (or as a consequence of):  Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause, Disease or injury.											
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or	as a conseque	ence of):								
.O. Box 6	death certific e attending p ad for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal of tat time of dea	death 3	Ectopic pregnancy Other (specify)				2	3d. Date of d Month		⁄ear
rds, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant condition	s contributing to death	h but not resul	lting in the ur	nderlying cause give	n in Part I.		1	es 2 <del>X</del>	_	to the cause of de	
Vital Record	The ate h page	Completed								24a. Was a autop perfor	sy	24b. Were a prior to death?	autopsy findings a completion of ca s 2 \( \text{No} \)	available ause of
of Vit	Physicien: this certific ral director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	atient 2□E	R/Outpatien	t 3 DOA Othe			(Check only or ne 5 <b>X</b> Resid		□Other (Sp	ecify)	
	Attending P r death. sctor: After ti by the funera		27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date of li (Month, I	njury Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y	at ? ∕es 2 □ N		8d. Describe h	ow injury	occurred		
Division	al or Attences after death	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of	Injury - At hon etc. (Specify)	ne, farm, stre	eet, factory, office		2	8f. Location (S City or Tow	itreet and n, State)	Number or F	Rural Route Numb	ber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1X Certifying (Check only one) 1 Medical Ex	Physicien: To the be caminer: On the basis and manner	s of examination	riedge, death on and/or inv	estigation, in my op	inion, deat	l place, a h occurre	nd due to the c d at the time, c	ause(s) a date and p	and manner a place, and du	as stated. ue to the cause(s)	)
		Σ	29b. Signature and title of eartifier	//	4		29c. License						2004	
7	30		30. Name and address of person with				Print)						, 2004	
	Sta	te	Fred Smith, M.D  31. Date filed (Month, Day, Year)	32. Regi	sconsi strar's Signatu		ue #1300,		vy Cl	nase, M	D 20	0815		
*	Registr	91	NOV 17 2	2004	war	19	Sparks	/						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year Mary Elizabeth Scott November 18 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 19 Tree Lane E1kton Ceci1 5. Social Security Number 8. Date of Birth (Month, Oay, Year) AUG 24, 1927 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕏 F Yrs Director 218-28-1012 New Jersey Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or items 23s or 28s-f show other treumstic event, the Medical Evarinar must be notified at Director 1 Yes 2 No Ceci1 Maryland E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Tree Lane 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "neturel", any injury or other treumatic event, the Medical Exe ORGE. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Mail Sorter Postal Service 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Floyd Leslie Atkinson Ellen Hoffman James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy L. Smith/Daughter 392 Nottingham Road, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of November 20c. Location - City or Town, State West Chester, cemetery crematory or other place)

o. A Ferris &

o. Inc. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 19, 2004 22. Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End stuge disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE esn esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has t autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending after death. death. М 1 Yes 2 No investigation 2 Accident 6 Could not be determined within 24 hours after dea To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signalure and title q 29d. Date signed (Month, Dav. Year) 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) It Far Kas, regons 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

State of Maryland / Department of Health and Mental Hygiene 004 38424 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Margaret F. Schnatz 16:50PM 2004 November 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Union Hospital Cecil 
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth

 Months
 Days
 Hours
 Min.
 June.
 3,1923
 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 81 Yrs. Director PA 192-12-5508 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 V☐ No Director MD Cecil Elkton 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1031 Jackson Hall School Road 21921 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: hours after 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Flanagan Margaret Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 st ment of Heatth and ant: If Item 27 is n 1031 Jackson Hall School Road, Elkton, MD Joseph C. Schnatz/husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11-22-2004 20c. Location - City or Town, State 1 X Burial 2 X Cremation 3 □ Removal from State 5 permit. Page Department o Important: If any injury or once. Delaware Veterens Cemetery Bear, Delaware ' 4 ☐ Donation 5 ☐ Other (Specify) Ineral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P 111 S. Queen Street, Rising Sun, MD 21911 21. Sign sture 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Encephalopathy Physician /Medical Examiner INFARETION MYOCARDIAL Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed the burial-transit ARTERY COKOIVARY and Due to (or as a consequence of) Box 68760 attending physician Physician/Medicai use as I 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the al Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient Certification: To 1 Tes 2 ER/Outpatient 3 DOA within 24 hours after death.

To tha Funaral Director: After thi
completely filled in by the funeral. 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0051197 NOVEMBER 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street , WILMINGTON DE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 9 2004 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	laryland		artmen rtificat					giene Reg. No.	00"	38425	
	Physici		Decedent's Name (First, Middle,     Market Exactles	,							2. Date of De. Month	Day		3. Time of Death	
	/Medi Examir		Mary Evely 4a. Facility Name (If not institution,				4b. City,	Town, or	Location o	of Death	Nov.	1 2 4c.	County of I	004 7:53p M	_
			Crofton Conva	lescent (	enter	t hinth days	If I Inder	Cro	fton	24 Hrs	9 Data of Bio	1	Anne	Arundel	
	Funeral Director		219-74-7606	5. Sex 7. A 1 □ M 2 🖾 F	75	Yrs.	Months	Days	Hours	Min,	8. Date of Bin (Month, Da Jul. 2	y, Year)	29	Birthplace (State or Foreigr Country) MD	7
	yland sow		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Town or Lo	ocation							10d. Inside City Limits	
	Ba-f eh	ctor	MD				Bal	timo	re					1 ☐ Yes 2 🛣 No	
	with the	Funeral Director	10e. Street and Number 7070 Timberfie	ld Road			10f. Zip	Code	21226	5		10g. Citi	izen of Wha	t Country? USA	
	death	nera	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13.	Was Deced	ent of Hi			ecify Yes or No Rican, etc.)	-		American Indian,	_
5-0036	72 hours after death with the Maryland natural', or iteme 23e or 28e-f ehow diest Evander must be rodified at	Š	1 ☐ Wever Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced		No		1 ☐ Yes		Specify:	i, rueito	nican, etc.)		Specify:	White, etc. White	
15-0	n 72 hours "natural", edicul Exa	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usua kind of wo DO NOT us	rk done d	lurina mosi	t of worki	ing	16b. Ki	nd of Busin	ess/Industry	
2121	giene.	Somp	Elementary/Secondary (0-12)  5	College (1-4or	5+)		N/						N/Z	Α	
Maryland	s 1 and 2 should be filed within 72 hc f Health and Mentai rlygiene. item 27 ie marked other then "natur other traumatic event, the Medical	To Be (	17. Father's Name (First, Middle, L. Charles Henry S	*						er's Name Cy Si	(First, Middle, .mms	Maiden	Surname)		
Mar	d 2 sho		19a. Informant's Name/Relationshi Helen Sevec/Sis				-				al Route Numbe Terna Pa	-		ite, Zip Code) 21146	
			20a. Method of Disposition		com	e of Dispo	osition (Nari	ne of	1		Date			y or Town, State	
Baltimore,			1 XBurial 2 ☐ Cremation : ' 4 ☐ Donation 5 ☐ Other (Spe	ecify)			at. C			NOV.	17, 2004	Ba	altimo	ore, MD	
Balt	permit. Pag Dep riment Important; if any injury o		21. Signature of Fune al Service Li	5 Oll	,		Barra 495 G	nco	& Son	is, P	A. Sev	erna erna	a Park a Park	K Funeral Hom	е
Я			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that cause nly one cause on each	d the death. I line.	Do not ent	er the mod	e of dying	g, such as	cardiac c	or respiratory ar	rest,	80/11/2017/11	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		s a consequen	C 000	Ad	en	o Ca	nc	inon	101		months	Š
	Examiner		Sequentially list conditions	B 30	east	( C	an	cin	on	101	inon			years.	
	lad nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequen	ice of):								9	
oʻ	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	c Due to (or a	s a consequen	ice of):									
8760,	ate be hysicia the bur	dicai		d											
9 xo	leath certifica attending ph I for use as th	0	IF FEMALE:	23c. If yes, outcome	e of pregnancy	,							23d. Date of	dolivan	
O. B	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal de	ath 3	Ectopic pr Other (sp						Month	Day Year	
s, P	es that igned b	by Pl	Part II. Other significant condition			- n		-	n in Part I.		23e. Did to	obacco u	se contribut	te to the cause of death?	
ord	v require been si should l	eted	Cononen	Atn	enos c	ken	051	2			1 D Y	es 25	ZN0 3□	Probably 4 Unknown	
Records,	0 - 0	Completed					<del></del>				24a. Was autop perfor	rmed?	prior		
Vital	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Death	1 Yes	ne)	10	Yes 2□No	
of	Phys this ral di	2	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpat  28a. Date of Inj (Month, D.	ury 28	Outpatier  b. Time of Injury		8c. Injury Work	4 2000	-	me 5 ☐ Resid 28d. Describe h			Specify)	
Division		catic	2 Accident investigation inve	ot be			М	1 🗆 Y	′es 2 🗆 l		29f Lagation //	*****	d Marenton a	a Court Court Mount	
Div	of or Attency after death Director: d in by the	Certification:	4 ☐ Homicide determin	ed 28e. Place of Ir building, e	itc. (Specify)	, rarm, str	eet, ractory	, опісе		4	City or Tow			r Rural Route Number,	
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying 2 Medical E	Physician: To the besi xaminer: On the basis and manner s	of examination	dge, death and/or in	n occurred vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the dead at the time, d	cause(s) date and	and manne place, and	er as stated. due to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier	20-				License		1.0		29d. Date	a signed (M	Ionth, Day, Year)	
•		114	, Kall	yn a	101	41			20			-	1112	101	
			30 Name and address of person w  RAKESIT A  31. Date filed (Month, Day, Year)	ROPA, I	death (Item 23 4300 trar's Signature	GA	Print) FLL F	1~	7 1	Fox	LN, BO	ow	112,	MD20715	
	Sta Registi	-		6 2004	Secondary /	la for	marke								

			1 - For State Registrar	State of M		partment of Certificate of		Mental Hygi	ene 004	38426
	Dhusia		1. Decedent's Name (First, Middle, La	st)	-			2. Date of Death Month		3. Time of Death
	Physici /Medi		Barbara A. Sore	ynit				Novembe:	$r^{Day}$ 14, $2004$	9:50 AM
7	Examir	ner	4a. Facility Name (If not institution, giv				n, or Location of Dea	ith	4c. County of Death	
			Crofton Convale  5. Social Security Number 6. S				Crofton  ar   If Under 24 Hr	e   0 0 . (B: :)	Anne Ar	
	Funeral Director				e (In yrs. last birtho 89 Yrs	Months Da			rear) Cou	place (State or Foreign intry) Cyland
	D		Usual Residence of Decedent					OCC. 22,	, 1515 Pal	Lytanu
	arylar show	ڀ	10a. State 10b. County		10c. City, Town o	r Location	- •			10d. Inside City Limits
	8a-f	Director		rundel			Crofton			1 ☐ Yes 2 🙀 No
	with t	급	10e. Street and Number 2131 Davidsonvil	lo Pond		10f. Zip Cod	• 21114	109	g. Citizen of What Cou	
	death ns 23	Funeral	11, Marital Status	12. Was Decedent	Ever in U.S.	3. Was Decedent		Specify Yes or No-	U.S.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other then "natural", or Items 23s or 28e-f show other traumatic event, the Medical Examinar must be modified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☑  If Yes, Give  Year or Dates:	No	If Yes, specify O	of Hispanic Origin? (: uban, Mexican, Pue No <i>Specify:</i>	rto Rican, etc.)	Black, White,	
21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. De	cedent's Usual Oc	cupation	16	5b. Kind of Business/Ir	ndustry
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or !	/ii	e. DO NOT use rei	ne during most of wo tired)	orking		
	ygier ygier her th		12			Homemake			Own Hon	ne
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mer	Be	17. Father's Name (First, Middle, Last, Onufry Krasowski					<sub>ime (First, Middle, Ma</sub> a Baron	uiden Sumame)	
7	should nd Me mark imatic	To	19a. Informant's Name/Relationship (		19b. M	ailing Address (Stre			City or Town, State, Zip	n Code)
	1 and 2 : Health au em 27 is		Patricia Wroten/	• • • • • • • • • • • • • • • • • • • •			Hills Ct.			21012
Baltimore,	0 0		20a. Method of Disposition  1) □ Burial 2 □ Cremation 3 □  1 □ Donation 5 □ Other (Specif		20b. Place of Di cemetery, Hillcre	sposition (Name of crematory or other p St Mem. G	n/aca)		oc. Location - City or Tennapolis,	
Baltin	permit. Pag Department Importent: I eny injury o		21. Signatur uneral service Licer		On				lor Funera Annapolis,	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not		-			Approximate
	Physician		Immediate Cause (Final disease or condition	One cause on each	To boils		Dienne	in .		Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	N.E. (-)	1 )29)			(Jegr)
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b	0					
SU	led nsit	nine	if any, leading to immediate cause (Disease or injury	Due to (or as	a consequence of):					
,	execunate and al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
8760,	cate be executed physician and the burial-transit	dical	(	d						
9	ntifical ng phy as th	Medi	TE TE LANGE							
Вох	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	Physician/Me	1F FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		3 □Ectopic pregna	ncy		23d. Date of delive	•
O.	at the dea by the a tached fo	ysici	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 Other (specify)			Month	Day Year
4	that the ed by detac		Part II. Other significant conditions of	ontributing to death b	ut not resulting in th	underlying cause	given in Part I.	23e. Did toba	cco use contribute to the	he cause of death?
Records,	uires sign	d by						1 ☐ Yes		pably 4 Unknown
00	w requir s been s s should	ompleted						24a. Was an	24b. Were auto	ppsy findings available
Re	The lav ate has page 2	mo						autopsy performe 1 ☐ Yes 2 ☐	d? prior to co death?	mpletion of cause of
Vital	10 LT	BeC	25. Was case referred to medical				26. Place of De	1 Yes 2 4 ath (Check only one)	112195	21 140
of V	d Si	70 E	examiner? 1 Tes 2 The	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpa	ient 3□ DOA	Other: Harsing I	Home 5 Residence	e 6 □Other (Specif	50)
		ü.	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju- (Month, Day	ry 28b. Time (Year) Injur	у У	jury at vork?	28d. Describe how	injury occurred	
isio	tor:	cat	2 Accident investigation 3 Suicide 6 Could not be		In Athama fam		☐ Yes 2 ☐ No	206		
Division	Dir	Certification;	4 Homicide determined	building, etc	ury - At home, farm, c. (Specify)	street, factory, onto	:e	City or Town, S	et and Number or Rura State)	AI Houte Number,
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowledge, de	ath occurred at the	time, date and place	e, and due to the caus	se(s) and manner as s	tated.
	he Hc in 24 I he Fu pletely	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and/or	investigation, in m	y opinion, death occi	urred at the time, date	and place, and due to	o the cause(s)
L.	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Lice	nse number	29d	Date signed (Month,	Day, Year)
,			1 miller	1 mm		D	55848	1	1115/04	
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type 2 o M	e, Print)	61	111 1 1	21000	
	Sta	to	31. Date filed (Month Day Year)	32. Fabistra	Syll on	1º Hing	Gamb.	njiy my)	21057	
	Registr		NOV 16	Z004	w st	A CONTRACTOR OF THE PARTY OF TH				

		1- For State of Mary Registrar		artment of Health an rtificate of Death		2004 38427						
Physi	cian	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death						
/Med	lical	Paul C. 4a. Facility Name (If not institution, give street and number)	Twigg	41 Ch T	November	30, 2004 6:50 a <sup>M</sup>						
Exam	iner	11000 Applewood Drive N.W.		4b. City, Town, or Location of D LaVale	eath	4c. County of Death Allegany						
Funera	1	5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If Under 24		9 Birtholace (State or Foreign						
Directo	r	193-14-6552	Yrs.	words says mode	Ain. Aug 28,	1923 PA						
yland		10a. State 10b. County 10	c. City, Town or Lo			10d. Inside City Limits						
e Mar 3a-f et	ctor	MD Allegany	LaVal	e 		1√ Yes 2 No						
Ind 21215-0036  be filed within 72 hours after death with the Maryland tall Hygiene. Ind other than "natural", or items 23a or 28a-f ehow event, the Medical Examinar must be notified at	Funeral Director	100. Street and Number		10f. Zip Code 21502	10g	D. Citizen of What Country?						
death ms 23	era	11000 Applewood Drive N.W.  11. Marital Status  12. Was Decedent Ever	in U.S. 13.		(Specify Yes or No-	USA 14. Race - American Indian,						
after or Ite	FE	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po	uerto Rican, etc.)	Black, White, etc.						
hours tural',	ed by	3 Wildowed A Divorced Year or Dates:				Specify: white						
215-	plete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working 16	6b. Kind of Business/Industry						
of filed within all Hygiene.  other than "went, Int. Mark	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Pipefitt	ter	Ва	&O Railroad						
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Example.	Be	17. Father's Name (First, Middle, Last)  William L. Twigg			Name (First, Middle, Ma							
Iltimore, Marylar iii. Pages 1 and 2 should be arment of Health and Menta ortant: If item 27 is marked injury or other traumatic as	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailiu	ng Address (Street and Number or	Louise Minni							
Te, Ma 1 and 2 s Health ar tem 27 is		Dorothy Detrick daughte	r 242	Bond Street	Cumber	rland MD 21502						
Baltimore, I permit. Pages 1 and Department of Healt Important: If item 2 any injury or other		1 Rurial 2 XCremation 3 Removal from State		natory or other place)		c. Location - City or Town, State						
Baltimor permit. Pages Department of Important: If it		`4 □Donation 5 □ Other (Specify)		neral Home, PA		Cresaptown MD						
Bal permi Depar Impo		21. Signature of Funeral Service Licensee	//. 22	Name and Address of Facility Scarpelli Funeral								
		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	108 Virginia Aven er the mode of dying, such as card	lue: Cumberlar	Approximate						
Physician		Immediate Cause (Final disease or condition Havenced Hepo-to Cellular Carcineme Onset and Death										
/Medica Examine		resulting in death)  Due to (or as a co		7 . 10 3011 101		2 Menty						
LXamme		Sequentially list conditions, b. Due to (or as a condition)	management off.									
de uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	isequalics or,									
O, exect an and rial-tra	Exa	resulting in death) Last  C.  Due to (or as a continuous)	sequence of):									
I Records, P.O. Box 68760,  The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal	d										
Box 60 eath certific attending p	/Med	IF FEMALE: 23b. Was decedent organizated and 23c. If yes, outcome of pr	egnancy									
Box death cerr a attendin d for use	Physiclan/Me	in the past 12 months?  1 Ves 2 No 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year						
P.O. that the de detached is	hys	9 Unknown										
dS, Fires that signed to be detailed	by	Part II. Other significant conditions contributing to death but no	resulting in the ur	nderlying cause given in Part I.		cco use contribute to the cause of death?						
Records, he law requires the has been signerge 2 should be c	eted				1 🗆 Yes	2 No 3 ☐ Probably 4 ☐ Unknown						
The lav	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?						
	O O	25. Was case referred to medical		26. Place of F	1 ☐ Yes 2 Death (Check only one)	No 1 Yes 2 No						
	To B		2 ER/Outpatien	Cthon	1	e 6 Other (Specify)						
SION O'		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred						
Division of tor Attending Physatter death. Director: After this lin by the funeral di	flcat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury	At home, farm, stre	M 1 Yes 2 No	28f Location (Stree	at and Number or Rural Route Number,						
Dirigin	Certification:	4 Homicide determined 28e. Place of Injury - building, etc. (St	ecify)	301, 1200, 31100	City or Town, S	Sta re)						
To the Hospital or within 24 hours after To the Funeral Dis		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of example and manager stated	knowledge, death	occurred at the time, date and pla	ace, and due to the caus	e(s) and manner as stated.						
o the lithin 2. 5 the formula	Medical	one) and manner stated.  29b. Signature and title of certifier		29c. License number		Date signed (Month Day Year)						
+ 3 F 8		N.A. Kan Than			290.	Nov. 30th 2004						
		30. Name and address of person who completed cause of death	(Item 23a) (Type, I	D19318 Print)		TYUY SUN DUY						
10		N.A. Ranjithan, M.D.; 517 Old		ad; Cumberland,	MD 21502							
S Regis	ate trar	31. Date filed (Month, Day, Year) 32. Registrar's S		Located								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U D La Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William Paul Tarbert November 27, 2004 0352 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 3/11/1945 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Min 1**⊠**M 2□ F 59 220-42-6921 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 XYes 2 No Be Completed by Funeral Director MD Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1807 Larch Drive 21040 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1∑No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service U.S. Government 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul E. Tarbert Ella Mae Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Malcolm E. Tarbert (Brother) 1807 Larch Drive, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baker Cemetery 12/1/04 Aberdeen, Maryland <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metust **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 415 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: P.O. Box If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, þ 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 1 XNatural 5 Pending efter death. | Director: Af investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 84 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Rel Air Atwood 602 ASHKAN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 03 2004

1/27/04

32. Registrar's Signature

		,	1- State of Maryland / Dep. Registrar Ce	artment of Health and rtificate of Death		ene 2004	38429
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medio		Robert Lee Tharp		November		8:18 <sup>aм</sup>
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	eath	4c. County of Deat	h
			7600 Maple Avenue, #505	Takoma Park		Montgo	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 212-54-1161 7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year   If Under 24 H   Months   Days   Hours   M	Irs. 8. Date of Birth (Month, Day, May 26,	9. Birt 1950 Mar	hplace (State or Foreign ountry) Yland
	pud *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits
	Aarylé f sho	ŏ					1 ☐ Yes 2 █No
	the 28a-	Directo	Maryland Montgomery Takoma  10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	3a or		7600 Maple Avenue, #505	20912		USA	
	ms 2	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ame	
350	n 72 hours after death with the Maryland "natural", or items 23e or 28e-f show valce Executed the retified at	by Fui	1 Never Married 2 Married 1 Yes 2 No	1  Yes 2 No Specity:	esto ricati, etc.)	Black, White Specify: B1 a	e, etc. ick
Ž	72 hou		15. Decedent's Education 16a. Dece	dent's Usual Occupation	unding 1	6b. Kind of Business/	Industry
9500-612	be filed within 72 ho tal Hygiene. d other than "natu	Completed	(Specify only highest grade completed) (Give life.	kind of work done during most of DO NOT use retired)	WOIKING		
	filed within Hygiene. sther than ent, It e Ma	Con	1 Roc	fer/Mover			on/Furniture
and Z	ild be filed lental Hygic ked other lic event, I	e	17. Father's Name (First, Middle, Last)		Name (First, Middle, M		
	should be nd Menta marked matic ev	ဥ	Wade D. Tharp	ng Address (Street and Number or	Marie Car		Zin Codo)
Mary	d 2 st th and 7 Is n traur		7.00	Maple avenue, #			
	Heal Heal tem 2		20h Place of Disposition	osition (Name of		Oc. Location - City or	
ē			1 Burial 2X Cremation 3 Removal from State  1 Donation 5 Other (Specify)  Cre	ropolitan		lexandria,	Virginia
daltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic erose.		2 2	2 Name; and Address of Fightyn			
ñ	Per Imp			000 University B			g,MD 20901
П			23a. Part / Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as card	diac or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	nation ha	nummi		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of)		neumonic		
	LAMITHE	<b>.</b>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	nge of me	neal flat	us	
	ted Isit	Examine	cause. Enter Underlying Cause (Disease or injury	0			
_6	axecur and al-trai	xar	that initiated events resulting in death) Last C Due to (or as a consequence of):				
3/60	cate be executed physician and the burial-transit	dical E	d				
ρ	tificat ig phy as th	ledi					
ROX	death certific e attending p id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Felal death 3 □	Ectopic pregnancy		23d. Date of deli	
o O	it the death certifii by the attending p tached for use as	Physician/Me		Other (specify)		Month	Day Year
7.	that the	Phy	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I	23e Did toba	acco use contribute to	the cause of death?
rds,	The law requires that the te has been signed by the age 2 should be detache	ed by	(13 Crom's desease			2 □ No 3 □ D1	
Hecord	law re as be 2 sho	ompleted	a Degenerative desi c	lesasi	24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
ř	- G 11	Com			perform	ed? death?	2 No
Vital	clan: ertific	Be (	25. Was case referred to medical examiner?		Death (Check only one	)	
0	Physiclan: this certific ral director,	2	1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpatien		g Home 5 Thesiden		cify)
	ling After fune	on:	27. Manner of Death 1 □ Deaturat 5 □ Pending (Month, Day Year) 28b. Time of Injury	f 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	v injury occurred	
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2	al or Attenos after death	Certi	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	,, <u>-</u>	City or Town,	State)	
	To the Hospital or within 24 hours after To the Funeral Direction Completely filled in the Funeral	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and pla vestigation, in my opinion, death o	ace, and due to the cau courred at the time, dat	use(s) and manner as o and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	296	d. Date signed (Month	n, Day, Year)
			· Mu	5614	17	1(116/	59
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		1.01	
_				Carroll Avenue,	#205, Take	oma Park,	MD 20912
	Sta Registr	-	31. Date filed (Month, Day, Year)  NOV 1 7 2004  32. Registrar's Signature	Sparks			

		Please	Type or Pri					_		egible.	
		1_ State	State of M	aryland			lealth and N	vientai Hy	giene	004	201.20
		Registrar	4)		Cenn	icate of I	Death	2. Date of Dea		004	38430
Physic	ian	1. Decedent's Name (First, Middle, L					with the	Month	Day	Yeer	
/Medi		Anna Taylor  4a. Facility Name (If not institution, g		1.	41	City Town or	r Location of Death	Nov.		2004 ounty of Death	1:55 p <sup>™</sup>
Exami	ner					_	inton			ince G	eorge
Funeral		Clinton Nursir 5. Social Security Number 6.	Sex 7. Ac	ge (In yrs. las	t birthday)	Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h		place (State or Foreign
Director		579-86-7032	1□M 癸F	45	Yrs.	onths Days	Hours Min.	June			
D		Usual Residence of Decedent		T40- 01- 3							Od. Inside City Limits
arylar show	_	10a. State 10b. County		İ	Town or Locati						1 ☑ Yes 2 ☐ No
88-f	Director	D.C. None		Was	hingt	On 10f. Zip Code			10a Citiza	n of What Cour	
with the	급	10e. Street and Number							1		
eath ne 23	Funeral	4421 Texas Av	7e S.E.	Ever in U.S.	13. Was	2001 Decedent of H		pecify Yes or No-		ed St.	
ter d	'n	1 Never Married 2 Married	Armed Forces	?			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White,	etc.
urs at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		10	Yes 2⊡kNo	Specify:		Sį	pecify: Bla	ack
il Z I 3-UUSO within 72 hours after death with the Maryland ene. than "natural", or Itema 23s or 28s-f ahow ta Medical Examinat must be notified at	Completed	15. Decedent's	Education	1	16a. Deceden	t's Usual Occup	ation during most of work	kina	16b. Kind	of Business/In	dustry
thin 7	nple	Elementary/Secondary (0-12)	College (1-4or	5+)			during most of world)	9		4	
A Signary Signary Control of the con	Con	12				Cook				ood	
Tal Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, La	st)				18. Mother's Nam	_	Maiden Su	imame)	
Via ould Men warks	2	Lattie Jon			400 14 111 4	(0)	Mary H and Number or Ru	laywood	0:	- Chin 70	0-41
BAITIMOYE, MARYJANG ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23s or 28s-f show any injury or other traumatic avent, the Medical Examinar must be notified at any once.	1	19a. Informant's Name/Relationship						S.E. Wa			
Heatt	1	Mary Jones/M	other	20b. Plac	e of Disposition	on (Name of		Date Wa		tion - City or To	
To ages	,	1 ☐ Burial 2 ☐ Cremation 3		)	•	ory or other place		1 10 4			
Saltimore, Sermit. Pages 1 a Department of Her mportant: If than my injury or othe		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		RIV	/erdal	e Crem	natory 1 ss of Facility Sn	1-18-0	4 R	Croma	ile,Md.
Department		Jan &					orgia Av				
THE TAN		23a. Part1. Enter the 3i ease, or co shock, or heart failure. List on	implications that cause	d the death.						asn. L	Approximate
Division		Immediate Cause (Final									Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Cardi	opuln	nonary	Arres	st				
Examiner											
	Jer	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Utina to (or ar	a consaquer	nce of):						
cuted nd ransi	Examiner	that initiated events	c. Anemi	a							
60, be executed sicien and burial-transit		resulting in death) Last	Due to (or a	a consequer	nce of):						
<b>58/c</b> ifficate be g physic as the b	dical		- Sepsi	is							
	Physiclan/Medic	IF FEMALE:	23c. If yes, outcome	of pregnance	-v				024	d. Date of delive	
Box eath cer attendin for use	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal de	eath 3⊟Ec	topic pregnancy	1		230	Month	Day Year
. 0 0 2	ysic	1 ☐ Yes 2XX No 9 ☐ Unknown	9□ Unknown	it time of deal	50	(specify) _					
- E D B	/Ph	Part II. Other significant conditions	s contributing to death	but not resulti	ing in the unde	rlying cause giv	en in Part I.	23e. Did to	obacco use	contribute to ti	he cause of death?
VITAI HECOTGS, siclan: The law requires t certificate has been signe rector, page 2 should be o	d by	Decubitic Ul	cer					101	/es 2□1	No 3□Prot	oably 4 Unknown
w require	Completed							24a. Was		24b. Were auto	psy findings available
The lav	dwc	- Dehydration							rmed?	prior to co death? 1 ☐ Yes	mpletion of cause of
VITAL	a	Malnutrition 25. Was case referred to medical					26. Place of Dea	1 ☐ Yes		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2010
Of Vita Physician: r this certific ral director,	0 8	examiner? 1 ☐ Yes <b>2∕O</b> No	Hospital: 1 ☐ Inpat	ient 2 EF	NOutpatient	3 DOA Oth	or	ome 5☐Resid	- 1	Other (Specif	(v)
	i ii	27. Manner of Death 1- Natural 5 □ Pending	28a. Date of Inj (Month, D	ury 2:	8b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe h	now injury o	occurred	
andin auth. or: Af	atlo	2 Accident investigat	tion				Yes 2 □No				
DIVISION OF alor Attending Physical British after death. I Director: After this d in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	_ ZOU. PIACE OF IT	ijury - At homoto. (Specify)	e, farm, street	, factory, office		28f. Location (S City or Tox	Street and h vn, State)	Number or Rura	al Route Number,
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DIVISION O  To the Hospitel or Attending PI within 24 hours after death. To the Funerel Director: After to completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examination	edge, death oo n and/or inves	curred at the tir tigation, in my o	me, date and place pinion, death occu	, and due to the cred at the time,	cause(s) ar date and pl	nd manner as s ace, and due to	tated. o the cause(s)
thin 2 the omple	Mec	29b. Signature and title of certifier	and mainers	ialeu.		29c. Licens	e number		29d. Date s	signed (Month,	Day, Year)
1		I have an .	1 1/2			7	0-24209	3	11.	14.2	004
(		30. Name and address of person wh	no completed cause of	death (Item 2	3a) (Type, Pri		-1201		6 *		
		Abulhasan U.					ard Rd.	#101 C	lint	on, Mo	d. 20735
	tate	31. Date filed (Month, Day, Year)	32. Regis	rar's Signatur		Coaks					
Regis	trar	NOV 1 7 2	004	read	for 1	GUMAN	/				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 38431 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 13, 2004 11:30A. **Physician** VALENTIEN WARNER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S REXFORD PLACE ASSISTED LIVING LANHAM 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Hours Months Days **Funeral X**□M 2□F Aug. 29, 1921 83 New Jersey 140-16-6075 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 le marked other than "naturel", or Iteme 23a or 28a-1 show any injury or other treumatic event, Ita Marical Examinational perioditied at once. 1 Yes 2 No Prince George's Lanham Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 United States 9885 Greenbelt Road, #311 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) US POSTAL SERVICE Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helen Valentien McEwen Warner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karan Temple True/ niece 7A Hillside Road Greenbelt, Maryland 20770 20c. Location - City or Town, State 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metropolitan Crematory 11/15/2004 Alexandria, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, P.A. 21. Signature of Funeral Service Ligensee ward 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): FIBROSIS **Physician** /Medical Examiner SARCOIDOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consequence of Examine or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown HEYRIT FAILURE Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABLETES 1 ☐ Yes 2 ☐ No **2X** № 1 ☐ Yes 26. Place of Death (Check only one) funeral director Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Assisted Living Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🔀 No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident s after death the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide filled in by 4 T Homicide within 24 hours a

To the Funerel C

completely filled To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of c November 15, 2004 4.15 **り**55559 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
Thomas E. Maslen, M.D. 7525 Greenway Center Drive, #316 Greenbelt, Maryland 20770 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 17 2004

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene, 38432 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 15, 2004 LOIS T. WORCESTER **Physician** 7:30P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Prince George's Riverdale Crescent City Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 6, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours Months 1□ M 2□ F Yrs. 80 unknówn Director 335-18-9014 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland 10a State 10c. City, Town or Location 10d Inside City Limits 10b County Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than \*natural', or items 23a or 28a-f show any injury or other traumstic event, the Medical Examiner must be nothing as Prince George's Berwyn Heights 1 X Yes 2 □ No Maryland Funeral Director 10e. Street and Number 10f. Zip Code 20740 10g. Citizen of What Country? 8516 60th Place United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White δ 3 ☐ Widowed 4 X Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Computer Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8516 60th Place Berwyn Heights, Maryland 20740 19a. Informant's Name/Relationship (Type, Print) Robert A. Monroe -friend 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Metropolitan Crematory 11/16/2004 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Alzheimeris 1-eans Examiner Due to (or as a consequence of). Examiner the burial-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medicai Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ⊡ Unknown uleer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 ZIZNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA edicai Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 01852 November 15 2004 D pleted cause of death (Item 23a) (Type, Print) Queenstong Rd Hyattsolk New 20781 BEVORE MI 4203 31. Date filed (Month, 32. Registrar's Signature State Registrar

			For State Registrar	State of	Marylar	nd / Depa	artmen rtificat	t of H	ealth a	and Me	ental Hy	giene Reg. No		38433
			1. Decedent's Name (First, Middle, Las	st)						1	2. Date of De	ath Da	y Yee	3. Time of Death
	Physicia /Medic		Marie Elizabet	h Wals	h						Novemb			
	Examin		4a. Facility Name (If not institution, give	street and num	iber)		4b. City,	Town, or	Location o	f Death		4c	. County of D	eath
			Suburban Hospita					hesda		0.4.14==			Montgo	
ı	Funeral Director		5. Social Security Number 6. S 142-01-2514  Usual Residence of Decedent	9X □M 2∏F	7. Age (In yrs. 86		Months	1 Year Days	If Under : Hours	Min.	B Date of Bir (Month, Da May 24	th y, Year) ,191	8 Ne	Birthplace (State or Foreign Country) W Jersey
	land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Mary -f sh	to	Md. Montgom	nery	Pot	tomac								1 ☐ Yes 2 🙀 No
	n the	irec	10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of What	Country?
	th wit	aiD	11215 Seven Locks	Road #	301			2085	54			Uni	ted Sta	ates
	ems ems	Funerai Director	11. Marital Status	12. Was Deced	ces?	l.S. 13.	Was Deced	dent of His	spa <i>n</i> ic Orig	gin? (Spec , Puerto R	ify Yes or No ican, etc.)	)-	14. Race - A	merican Indian, hite, etc.
36	safte, or l	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Da	3		1 🗆 Yes	2 <b>∏</b> №	Specify:				Specify:	White
3	n 72 hours after death with the Marylar "neturel", or items 23e or 28a-f show plical Extending and the mullified at	edb	15. Decedent's Ed		163.	16a, Dece	dent's Usua	al Occupa	ıtio <i>n</i>			16b. K	ind of Busine	ss/industry
5	n "ne	piet	(Specify only highest gra	de completed) College (1-	Aor 5+)	(Give	kind of wo DO NOT us	rk done d se retired)	uring most	t of working	9			,
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2	be filed within 72 ho ital Hygiene. d other then "netul event, ire Modical		17. Father's Name (First, Middle, Last)								(First, Middle	, Maiden	Sumame)	
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Maryland	12 sh h and 7 Is m treum		19a. Informant's Name/Relationship				-	-				-	or Town, State e, Md.	
آ	1 and Healt em 2		Kevin R. Walsh (	(Son)	20b. F	Place of Dispo				Da				or Town, State
io i	ages ant of tr: If it		1 Burial 2 □ Cremation 3 2 4 □ Donation 5 □ Other (Specification)			cemetery, crer :• Mary				lov. 3	19,	Ham	ilton	New Jersey
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other treumatic evonce.		21. Signature of Funeral Service Licer		100		2. Name an				ol Fur		l Home	new derbey
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ji Ji	Physician <sup>*</sup>		Immediate Cause (Final disease or condition	a Broncl	hitis									Onset and Death Days
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80	atten atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live bii	rth 2 Feta	aldeath 3[	Ectopic pr					1	23d. Date of o Month	Day Year
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g	w require been sig should b										1 🗆	Yes 2	□ No 3□	Probably 4 XUnknown
Records,	e law re has beo je 2 sho	Completed									24a. Was		24b. Were	autopsy findings available to completion of cause of
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<u>d</u>	Physi this c	10	1 ☐ Yes 2X No 27. Manner of Death	Hospital: 1 In		ER/Outpatier			4   Nu		e 5 Resi		6 Other (S	pecify)
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2	in the	Certification:	4 Homicide	buildin	ig, etc. (Speci	fy)					City or To	wn, State	9)	
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical (	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exam	nysician: To the miner: On the ba and mann	sis of examina	owledge, deatl ation and/or in	h occurred vestigation	at the tim , in my op	e, date an inion, dea	d place, ar th occurred	nd due to the d at the time,	cause(s date and	) and manner d place, and d	as stated. lue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	50			]	. License					_	onth, Day, Year)
	10			XX CW				D3579	92			N	ovembe	r 15,2004
	( •		30. Name and address of person who						,,	<b>.</b>				0.50
	Y		Dr. Swaroop A. Ra		50 We	est Edn ature.			#.	524 R	ockvil	le,	Md. 20	0852
	Sta Registi		NOV 1 7 2004		معمد	B,	Span	Kel.						

			For State Registrar	State of Maryla	•	artment of H			giene 004	38434
	Physici:	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	Day Year	
	/Medic	al	Jacqueleyne 4a. Facility Name (If not institution, giv	re street and number)	Brown	4b. City, Town, or	r Location of Dea	November	4c. County of De	10:40 P <sup>M</sup>
	Examin		Southern Maryland			Clinto			Prince (	
	Funeral		Social Security Number     6. S	Sex 7. Age (In yrs	. last birthday Yrs.		If Under 24 Hrs Hours Min	. (Month, Day	y Year) 9. Bi	irthplace (State or Foreign Country)
	Director		110-44-2731 Usual Residence of Decedent	52	113.			July 6,	1952 F	lorida
	72 hours after death with the Maryland natural', or ffems 23s or 28s-f show Jisal Evaninal must be rudified at	_	10a. State 10b. County	10c. C	ity, Town or L					10d. Inside City Limits  XXX Yes 2 ☐ No
	28a-f	Director	MD Prince G	eorges	0x	on Hill			10g. Citizen of What C	
	h with	al Dir	6604 March Driv	e		207	46		USA	
	r deat	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Arr Black, Wh	
36	rs afte	by Fu	1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2 <b>X</b> (No If Yes, Give Year or Dates:		1 ☐ Yes 🏋 No	Specity:		Specify: R1	lack
21215-0036	ba filed within 72 hours after death with the Marylan stal Hygiene.  od other than "natural", or ftems 23s or 28s-f show of other than "natural", or ftems 23s or 28s-f show event, the Medical Examinat mast be rutilized at	ted	15. Decedent's E	ducation	16a. Dece	edent's Usual Occup	ation	orkina	16b. Kind of Busines	
121	_ × 01	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)	9	D+	
	filed within Hygiene. other than " ent, the Me	0	12 17. Father's Name (First, Middle, Last	')	<u> </u>	omemaker	18. Mother's Na	ame (First, Middle,	Pvt.  Maiden Sumame)	
/lan	should ba filled within and Mental Hygiene. s marked other than umatic event, I ha M	To B	Oscar Green				Edit	h Mae McC	ord	
Maryland	12 sho n and I is me raume		19a. Informant's Name/Relationship (						r, City or Town, State,	
	is 1 and 2 should by Health and Men item 27 is marke other traumatic		Michael Green/Bro 20a. Method of Disposition	20b.	Place of Disp	. 54th St osition (Name of	0.7		1e, FL 32 20c. Location - City of	2208 or Town, State
E	8 0		XX Burial 2 Cremation 3 C	Removal from State		matory`or other place		. 10, 04	Atlantic E	Beach, FL
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	nsee	A <sub>1</sub> 2	2. Name and Addres	ss of Facility	eral Home	1	
	<u>0</u> 0 = 0		23a. Part1. Enter the disease, or com	846	38	21 14th S	treet,	N.W., Was	hington, [	C 20011 Approximate
k			shock, or hear failure. List only Immediate Cause (Final	one cause on each line.	Hahl	Carun		0	95 f	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to or is a conse	equence of):	C-11 - 11 p	011/04	1 1210	101	
B	Examiner	L	Sequentially list conditions,	b. Due to (or as a conse	A contract of the same	2191				
	nted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		equence on.					
o,	The law requiras that the death certificata be exacuted ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
8760	the burian	dical	(	d		<del>.</del>				
9	eath certifica attending ph for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregi	nancy				23d. Date of de	elivery
. Box	death e atter id for u	Iclar	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		□Ectopic pregnancy □ Other (s <i>pecify)</i>	′		Month	Day Year
P.0	at the ded by the a	Phys	9 Unknown	9 Unknown	autice in the		on in Dad I	23a Did to	hagaa usa cantributa	to the cause of death?
ds,	uiras thai signed t d be det	by	Part II. Other significant conditions of	Newtus, 1	MDe	r tenst	0 9		. /	Probably 4 Unknown
Records,	w requi	Completed			01			24a. Was a	an 24b. Were a	autopsy findings available
l Re	The law cate has page 2	omi						autops perfor	med? death?	
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		eath (Check only or		
of	Physic r this ral dir	); To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time		4   Nursing	-	ence 6 Other (Sp ow injury occurred	ecify)
ion	Attending Physician: r death. ector: After this certification the funaral director.	atlor	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No			
Division		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attenwithin 24 hours after deat for the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying P	hysicien: To the best of my kr	nowledge, dea	th occurred at the time	ne, date and place	ce, and due to the c	ause(s) and manner a	as stated.
	To the Hospita within 24 hours To the Funeral completely filled	edical	(Check only 2 Medicel Exa	miner: On the basis of examinand manner stated.	nation and/or in	rvestigation, in my o	pinion, death occ	curred at the time, d	late and place, and du	ue to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mor	
•	1,		> S-O1CUn		02a\ (T	DO (	1552	>14 (	7.01.	2004
	K		30. Name and address of person who SYLVESTEN DK 31. Date filed (Month, Day, Year)	completed cause of death (Ite		on the R	4D, AS	07 0x0	Altily, 1	2004 ND 20745
	Sta Registi		DEC 0 6 200		Ly .	Sporth	/			

		1	State of Maryland / De	partment of F ertificate of		nd Mer		ene 0 0	4 38435
			Decedent's Name (First, Middle, Last)				Date of Death		3. Time of Death
	Physicia /Medic	al	William Edward Brookhart				ovember		004 10:06 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) Washington County Hospital	4b. City, Town, o Hagersto		Death		Washi	
	Funeral Director		5. Social Security Number 217-24-6010   6. Sex $74$ Yrs	Months Days	If Under 2	4 Hrs. 8. Min. J	Date of Birth (Month, Day, une 19	,1929	9. Birthplace (State or Foreign Country) Baltimore, MD
	pu »	-	Usual Residence of Decedent         10c. City, Town o           10a, State         10b. County         10c. City, Town o	Location					10d. Inside City Limits
	laryla show	ō	MD Washington Hagerst						1 ☐ Yes 2 ☑ No
	the N	rect	10e. Street and Number	10f. Zip Code			10	g. Citizen of W	/hat Country?
	h with	ai Di	11 N. Baltimore St. Apt. 1104	21740				USA	
	r deal	Funeral Director	Armed Forces?	Was Decedent of H     If Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)		- American Indian, k, White, etc.
20	rs afte	by Fi	1 Never Married 2 Married 3	1 ☐ Yes 2☐No	Specify:			Specify:	White
200-	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-f show eny injury or other treumatic event, the Modical Exactination in titled at once.		15. Decedent's Education 16a. De	cedent's Usual Occup	pation	of working	1	16b. Kind of Bu	siness/Industry
7	e. an "n	Completed	College (1 4or Ex)	ive kind of work done  DO NOT use retired  Author	d) -	_		Dal+im	one City
7	led wi			lousing Aut	`		isat Middle M	faiden Sumame	ore,City
2	d be findal Hed out	Be.	17. Father's Name (First, Middle, Last)			a E. (		aluen Sumam	<i>b)</i>
	should ind Men s marke umatic	2	Leonard R. Brookhart  19a. Informant's Name/Relationship (Type, Print)  19b. M	ailing Address (Street				City or Town, S	State, Zip Code)
M	and 2		Nettie D. Reese (daughter) 2749	Mancheste	er Roa	d West	tminste	er,MD 2	1152
ย์	es 1 a of He fitem r oth		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition cametery,	sposition (Name of rematory or other place	сө)	Date	2	20c. Location - 0	City or Town, State
Dallillion	Pages Iment of tent: If its jury or o		`4 Donation 5 Other (Specify) Howard	Medical Sh					gton,DC
000	permit. Departr Importe eny inju		21. Signature of Funeral Service Licensee	22AVIStanhadRe					20011
	402 <b>4</b> 4		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	3821 14th				ton,DC	Approximate
	Dhysisian		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		2.1	/		, )	Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a. CI-IRO II C C C C C C C C C C C C C C C C C C	3 10-CIV	2 /30	المعادية المعادية	1 for y	111561	126
	Examiner		Palerinalia						
	pe is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initialed events c.						
_	xecute and II-tran	Examiner	resulting in death) Last  C						
0/00,	icate be executed physician and s the burial-transit	dicai E	L a						
Ď	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	<b>⊕</b>	IS SEMALS.						
XOC	ath cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  □ Use birth 2 □ retail death   □ Use birth 2 □ retail death	3 ☐Ectopic pregnancy	у			23d. Date Mon	e of delivery hth Day Year
	that the death certifited by the attending for the detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify) _					
Ţ.	that the		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause giv	ven in Part I.		23e. Did tob	acco use contri	ibute to the cause of death?
פ	w requires that been signed b should be deta	d by	RENAL FAILIRE				1 🗌 Yes	s 2□No	3 ☐ Probably 4 ☑ Unknown
ecords	aw rec is bee 2 shor	Completed					24a. Was an autopsy	24b. W	Vere autopsy findings available prior to completion of cause of
		Com					perform	ed? d	leath? ☐ Yes 2☐ No
N II A	Physicien: The law this certificate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?	tions 20 DOA Oth		of Death (C	heck only one	9)	
ō	Phy this ald	To	1 ☐ Yes 2 ☐ No	IIBRIL 3 DOA	4   Nul			nce 6 Othe	· · · · · · · · · · · · · · · · · · ·
0	tending Ph leath. tor: After th the funeral	ition	1 Natural 5 Pending (Month, Day Year) Inju 2 Accident investigation	y Wor	rk? ∣Yes 2 □ N			,,	
UNISION	Atter octor by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office		28f.	Location (Str. City or Town,		er or Rural Route Number,
2	rs after or rs after or rel Dir	Cert							
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, continuous one)  Certifying Physician: To the best of my knowledge, continuous one of the basis of examination and/continuous one of the basis of the basis of examination and continuous one of the basis of the bas	eath occurred at the tile r investigation, in my o	me, date and opinion, death	place, and hoccurred a	due to the ca at the time, da	use(s) and mar ite and place, a	nner as stated. and due to the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier	29c. Licens	se number	,	29	d. Date signed	i (Month, Day, Year)
	(		The state of the s	205	5599	4	11	1/27/0	, 4
	1	-	30. Name and address of person who completed cause of death (Item 23a) (Ty		1	, ,	HA	SCKOTO	ME
	Ch		31. Date filed (Month, Day, Year)  32. Registrar's Signature	CARRO L	Lyve	#143	3 M	2 3/7	140
	Sta Registr		DEC 0 6 2004 America 15	Sporter!	/				

Physician  Medical Examiner  1. Decedent's Name (First, Middle, Last)  George William Brooks  2. Date of Death Month November 29, 20  4. Eacility Name (If not institution, give street and number)  4. County of the City, Town, or Location of Death County of the	9. Birthplace (State or Foreign Country)  Maryland  10d. Inside City Limits  1  Yes 2 No
Medical Examiner   George William Brooks   November 29, 20	of Death  Limore  9. Birthplace (State or Foreign Country)  Maryland  10d. Inside City Limits  1  Yes 2 No  that Country?  A.  American Indian,
FrankLin Square Hospital  Rosedale  Bali  Superal Director  Social Security Number  229-96-2517  Superal Director  Bali  To Age (In yrs. last birthday)  120	9. Birthplace (State or Foreign Country)  Maryland  10d. Inside City Limits  1  Yes 2 No hat Country?  A. American Indian,
Director  229-96-2517  Usual Residence of Decedent  229-96-2517  1X M 2 F 31 Yrs. Months Days Hours Min. (Month, Day, Year) Oct. 17, 1973	Maryland  10d. Inside City Limits 1 □ Yes 2 No hat Country? A. American Indian,
	1 □ Yes 2 No hat Country?  A.  American Indian,
Maryland Baltimore Baltimore    Maryland   Baltimore   Baltimore   10f. Zip Code   10g. Citizen of W	hat Country?  A.  American Indian,
10g. Citizen of W	· A .  · American Indian,
1612 Lule Count	- American Indian,
1613 Lyle Court  21234  U.S  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 \( \) Never Married  12. Was Decedent Ever in U.S. Armed Forces? 1 \( \) Never Married  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black)  14. Race Black	White etc
Armed Forces?  1 Never Married 2 Married 1 Yes, Specify:  1 Yes, Sive Fear or Dates:  Armed Forces?  1 Yes, Specify:  1 Yes, Specify:  Specify:  Specify:	, winte, etc.
The Never Married 2 Married 1 Types 2 No Specify: Specify	White
15. Decedent's Education (Specify only highest grade completed)  16. Kind of Bus (Give kind of work done during most of working life. DO NOT use retired)  16. Kind of Bus (Give kind of work done during most of working life. DO NOT use retired)  16. Kind of Bus (Artist Art	iness/industry
College (1-4or 5+)  September 2	
The proof of the p	)
Frank T. Brooks  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S	itate, Zip Code)
Nick Scarpulla Partner 1613 Lyle Court Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Local Date) 20c. Location of Competent Court State of Court Baltimore, Maryland 20c. Location of Court State of Court Baltimore, Maryland 20c. Location of Court B	21234
Controllery, Crematory or other place	City or Town, State
Roane Memorial Gardens 12-5-04 Harrimar  21. Signature of unital Service Specify Roane Memorial Gardens 12-5-04  22. Name and Address of Facility Ruck Towson Funeral Service Specify Ruck Towson Funeral Specific Specify Ruck Towson Funeral Specify Ruck Towson Funeral Specific Specify Ruck Towson Funeral Specific Specify Ruck Towson Funeral Specific Specify Ruck Towson Funeral Specific Specify Ruck Towson Funeral Specific Specify Ruck Towson Funeral Specific Specify Ruck Towson Funeral Specific Specify Ruck Towson Funeral Specific Specify Ruck Towson Funeral Specific Specify Ruck Towson Funeral Specific Specify Ruck Towson Funeral Specific Specify Ruck Towson Funeral Specific Spec	
22. Name and Address of Facility Ruck Towson Funera 1050 York Road Towson, Maryland	al Home, Inc. 1 21204
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician Immediate Cause (Final disease or condition resulting in death)  Narcotic intoxication	Onset and Death
Examiner	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
Due to (or as a consequence of):	
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O to the post of t	
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury) Last  Cause (Disease or i	ute to the cause of death?
1   Yes 2   No 3	Probably 4 Unknown
To see the proof of the proof o	ere autopsy findings available or to completion of cause of ath?
	Yes 2□ No
Tight and the second se	(Specify)
27. Manner of Death 28a. Date of Injury 28b. Time of Work?  1 Natural 5 Pending investigation invest	unk
To be the property of the prop	or Rural Route Number.
	7 Pulaski hwy vland
29a. Certifier  (Check only (C	ar as stated
one) and manner stated.  29c. License number O.C.M.E. November	
history M. 14 and	50, 2004
30. Name and address of person who completed ca se of death Item 23a) (Type, Print)  THE DIFF M. King 111 Penn Street, Baltimore, Maryland 2120	)1
State Registrar  State  31. Date filed (Month, Day, Year)  DFC 06 2004  Sequence 5  Sparks	

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F <i>rtificate of</i>	lealth and M <i>Death</i>	lental Hygie Reg		38437
Ī	Physici	an	Decedent's Name (First, Middle,  JEFF		F.	BALLAN		2. Date of Death		3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution,		Г•		or Location of Death	DECEMBER	1, 2004	4:56 PM
			6 WELLHAVEN C	RCLE #1328			OWINGS M	ILLS	•	ALTIMORE
	Funeral Director		216-40-1463	3. Sex 7. Ag 1	e (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, You JAN. 22, 1	9. Bir	thplace (State or Foreign ountry)
	laryland show		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f sh	tor	MD	BALTIMORE			OWINGS M	ILLS		1 ☐ Yes 2 💢 No
	ith the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	s 23a	ral	6 WELLHAVEN C				21117			USA
	ter de item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent I Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	72 hours after death with the Maryland natural; or items 23a or 28a-f show Jical Evantiner must be notified at	þ	3 ☐ Widowed 4 💢 Divorced	1 X Yes 2 N If Yes, Give Year or Dates:	ARMY	1□ Yes 2\ No	Specify:		Specify:	WHITE
5-0	72 hc	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occup	during most of worki	ing 16t	o. Kind of Business	/Industry
121	f within 72 ho liene. r than "natur the Medical	ldm	Elementary/Secondary (0-12)	College (1-4or 5	i+) /ife.	DO NOT use retired	d)		AUTO	
<b>d</b> 2	Hyg the		17. Father's Name (First, Middle, La	<u> </u>	EXECU	) I I A E	18. Mother's Name	e (First, Middle, Mai	AUTO	
Maryland		To Be	HAROLD		BALLA	N	EVE		MAY	TERREN
lary	2 sholl and h is ma		19a. Informant's Name/Relationship					al Route Number, Ci		Zip Code)
	tealth		JAMES E. BALLA	N / SON				BALTIMORE		
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic @		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3			natory or other plac	(e)		Location - City or	
Ħ	artme ortani injury		* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Euneral Service Lie				CEM. 12/3,		EISTERSTO	
ä	Depa Impo any ii		Rotal /			900 REIS	TERSTOWN I	L LEVINSO ROAD - PI	N & BRUS. KESVILLE.	, INC. MD 21208
П	*		23a. Part1. Enter the disease, or co shock, or heart failure. List or	implications that caused ily one cause on each lin	the death. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	<b>GUN SHOT</b>	TO HEAD				Onset and Death 5 MINUTES
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a consequence of).					
	nd	Examiner	that initiated events	с.						
90,	oe exe	I Ex	resulting in death) Last	Due to (or as a	a consequence of):					
68760,	tificate be executed g physician and as the burial-transit	edical		d						
Box (	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of deli	2001
B	death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1∐Live birth 2 4☐Pregnant at 1 9☐Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P. 0.	res that the death cer igned by the attendin be detached for use	Physician/N	9 Unknown							
ds,	signe d be c	by	Part II. Other significant conditions	contributing to death bu	it not resulting in the ur	iderlying cause give	en in Part I.	23e. Did tobacc		the cause of death?
Record	w requir been si should	lete						24a. Was an		
Re	ysician: The lavis certificate has director, page 2	Completed						autopsy performed	prior to death?	topsy findings available ompletion of cause of
Vita	ician: Th certificate ector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Death	1 ☐ Yes 2 💢	No 1 Yes	21 <b>X</b> No
2	E E =	2	1 X Yes 2 No	Hospital: 1   Inpatier		0the	er: 4 🗌 Nursing Hom	ne 5 🛣 Residence	6 Other (Spec	rify)
uc	ding Ph n. After thi funeral	tion:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) Injury	28c. Injury Work	at 2	8d. Describe how in	jury occurred	
Division of	Attending Physician: r death. ector: After this certifics by the funeral director,	fical	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Injur	rv · At home, farm, stre		Yes 2 No	GUN SHOT		roll (P. m. do W.) dimbor (N. d. D.)
	ospital or Attending I hours after death, uneral Director: After ly filled in by the funer	Certifications	4  Homicide determine	building, etc.	(Specify) HOME	or, ractory, critico	6	City or Town, Sta	EN CIRCLE	#1328
	Hospit 24 hour Funer tely fills	edical	[Ollock Olly 5 Windrich EX	Physician: To the best of	f my knowledge, death	occurred at the tim	e, date and place, a	nd due to the cauce	(c) and manner as	2111/
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Med	one) 29b. Signature and title of certifier	and manner stat	ed.	29c. License				
	^		1 Latin with	and AM	+	250. LICHISH			Date signed (Month	
	.9)	-	30, Name and address of person wh	completed cause of de	ath (Item 23a) (Type, F	Pript)	D18667		ECEMBER 3	, 2004
			Thelip Milile	llo A	hock s	nama	Um S	ch. Med	& Bar	to md.
	Stat Registra		31. Date filed (Monte Cay, Year)	2004 32. Refistrar	's Signature	Spark	Les	ch. Med		7

State of Maryland / Department of Health and Mental Hygiene

38138

					C	ertificate	of i	Death		Reg. No.	Oup	30430
я	Physic	ian	1. Decedent's Name (First, Middle, Las	0 1	- 1.				2. Date of Do		V	3. Time of Death
Ų.	/Medi		Josephine	Blasz	ak,				Month	2 4	Year O 4	12.05 PM
7	Exami	ner	4a. Facility Name (If not institution, give	street and number)	001-0	ca. 1-	4		or Location of Dea			
		д	Rowenwood p						more. M		ltime	
	Funeral		5. Social Security Number 6. Se 81 3 0 4 5 2 3 5	ex 7.Age( □M 2D)(F	In yrs. last birthday Q 2 Yrs.	/) If Under 1 Months	Year Days	If Under 24 H Hours M		rth ay, Year)	9. Birthpla Country	ce (State or Foreign V) UNK
	Director		Usual Residence of Decedent	T.	9 × 115.				3-1			
	land		10a. State 10b. County	1	Oc. City, Town or I	ocation					100	d. Inside City Limits
	Mary # sh	ō	MD		Balti						100	11X Yes 2 □ No
	288	Director	10e. Street and Number		121.7	10f. Zip C	ode			10g. Citizen of	What Countr	12
	3a or	<u>=</u>	501 W. Franklin	Street				21201			**TIAL COUNTY	<i>j</i> :
	ms 2	Funerai	11. Marital Status	12. Was Decedent Eve	er in U,S. 13	. Was Deceder	nt of H		(Specify Yes or No erto Rican, etc.)	USA 14. Bar	ce - Americar	n Indian
0	after or ite		Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give					erto Rican, etc.)		ck, White, et	c.
02	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "netural", or items 23a or 28a-f show event, the Medical Examiner must be mylfied at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No.	Specify:		Specif	y whi	te.
21215-0020	72 hc	Completed	15. Decedent's Edu (Specify only highest grad	ucation	16a. Dec	edent's Usual (	Occupa	ation	orking unk	16b. Kind of B	usiness/Indu	stry unk
7	thin 'e	Pie.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retirea	during most of w	orking Gille			ulik
2	er th	Ö	unk u	nk						}		
Maryland	tal H d oth	Be	17. Father's Name (First, Middle, Last)			ur	ık	18. Mother's N	ame (First, Middle	, Maiden Surnar	ne)	unk
<del>Z</del> a	should ind Men	ဂ္				-						
<u>la</u>	2 sho and Is m		19a. Informant's Name/Relationship (T)		19b. Mai	ling Address (S	Street a	and Number or I	Rural Route Numb	er, City or Town	, State, Zip C	ode)
	and eaith n 27 er tr		Ravenwood Nursing		5(	01 W. F	ran	klin St	reet Bal	timore,	MD 2	1201
0	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		20b. Place of Disp cemetery, cre	osition (Name matory or othe	of er plac	ө)	Date	20c. Location	City or Town	ı, State
<u>=</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be nufficed at once.		4 ☐ Donation 5 ☐ Other (Specify)	in state								
Baltimore,	Depart Depart Import any inj		21. Signature of Funeral Service Licens Ronald S.	ee Wade / Direc	tor S	2. Name and	Addres	s of Facility	rd 655 W	Do 1+4-		
ш	205 20		Mman 1	Mall		altimo:	re.	MD 21	201	• Daiti	nore Si	reet
			23a. Parkl. Enter the disease, or compleshock or heart failure. List only or	ications that caused the	e death. Do not er	iter the mode of	of dying	g, such as cardi	ac or respiratory a	rrest,	A	pproximate
	Physician		oriosingo riosat randro. Elst orily or	no cause on each line.								iterval Between Inset and Death
<i>}</i> -	/Medical		Immediate Cause (Final disease or condition	Metasta	etic l	iver .	di:	sease				
	Examiner		resulting in death)		e to (or as a conse							
	p #i	by Physician/Medical Examiner	<u></u>								į	
	law requires that the death certificate be executed as been signed by the attending physician and a 2 should be deteched for use es the bunal-trensit	хап	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Du	e to (or as a conse	quence ol).						
Ď,	be ex cian burial	Ë	Cause (Disease or injury									
0X 68/60	phys the	음	that initiated events resulting in death) Last	Due	to (or as a conse	quence of):						
×	ding Se ex	Me		J								
ď	atten for u	ciar										
j.	y the d	ysi	Part II. Other significant conditions con		ot resulting in the o	anderlying caus	se give	n in Part I.	23b. Did	tobacco use co	ntribute to th	e cause of death?
1	that hed b	4	Emphysema	•					1 🗆	Yes 2□ No	3 Probab	oly 4 Crunknown
ecoras,	v requires that the deat been signed by the att should be deteched for								24a Was	an autopsy	24b Were	autopsy findings
ဂြ ပ	v req beel shou	ete							perfo	rmed?	availa	ble prior to letion of cause
	The lay ate has page 2	Completed								- /	of dea	ith?
_	ficate		25. Was case referred to medical						1 🗆 1	**	1 🗆 Y	es 2□ No
>	hysician: The law his certificate has t il director, page 2 s	o Be	examiner?	lospital:	οΠ <b></b>		Othe	_	eath (Check only o			
ō	Phy r this eral o	٤	27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury	2 ☐ ER/Outpatie		Injury	4 A Nursing	Home 5 ☐ Resid	dence 6 ∐Otho now injury occurr		
0	ding th. Afte	윤	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury	М	Work	? ′es 2 □ No		ion injury occur.	00	
DIVISION OF	Atter r dea octor by the	100	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	At home, farm, st	reet, factory, of	fice		28f. Location (S	Street and Numb	er or Rural R	ou <i>te Nu</i> mber.
5	o efte	Certification:	4 Homicide	building, etc. (S	ipecify)				City or Tou	m, State)		
	To the Hospital or Attending Physician: within 24 hours feter death. To the Funerel Director: After this certifical completely filled in by the funeral director,		29a. Certifier 12 Certifying Phys	ician: To the best of m	y knowledge, deet	h occurred at the	ne time	e, date and plac	e, end due to the	cause(s) end ma	nner es state	.d.
	he Ho in 24 he Fu pletel	edicai	(Check only 2 Medical Examin	ner: On the basis of exa and manner stated	mination and/or in	vestigation, in	my opi	inion, death occ	urred at the time,	date and place, a	and due to the	e cause(s)
	With To 1	2	29b. Signature and title of certifier	to the same				number		29d. Date signed	d (Month, Day	r, Year)
			Alegomma M	wy new 17		D	علاً إ	17/6		11-24	-04.	
			30. Name and address of person who cor	mpleted cause of death	(Item 23a) (Type,	Print)						
			541101d Frederick			mD. o	110	124'				
	Sta		31. Date filed (Month, Day, Year) DEC 0 6 2004	32. Registrar's	Signature	books	-					
	Registra	1	MAN O O COUP	S. A. L.	1-	In a reside						

Registrar

			State of Maryland / Department of Health and M	-	_	
			For State of Maryland / Department of Health and N		Reg. No. 004	38439
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ath Day Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	-	27-2004 4c. County of Death	A.M.
	Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Franklin Square Hospital RosedalE		BOIT!	ove.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birtl		place (State or Foreign
	Director		Usual Residence of Decedent	AUE ak	1917 1/20	) YORK
	yland yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mar 3a-f sl	ctor	MARILARO BALTIPARE CARREY			1 Tyes 2 No
7	with the a or 21	Dire	10e. Street and Number		10g. Citizen of What Coul	itry?
AR	il Z i 3-UU30 within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-1 show ha Medical Examinar must be notified at	by Funeral Director	2820 WALTHER GLVO - APT 3104 21334  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 14 Marital Status) 15. Was Decedent of Hispanic Origin? (Sp. 15 Marital Status) 16. Was Decedent of Hispanic Origin? (Sp. 16 Marital Status) 16. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 17. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 17. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 18. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent Ever in U.S. 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent Ever in U.S. 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent Ever in U.S. 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent Ever in U.S. 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent Ever in U.S. 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp. 17 Marital Status) 19. Was Decedent of Hispanic Origin? (Sp.	pecify Yes or No-	14. Race - Amen	
( )	after or Ite	Fur	1 Never Married 28 Married 12 Yes 2 No	Hican, etc.)	Black, White,	etc.
~ 6	72 hours naturel;		3 Wildowed 4 Divorced Year or Dates: \(\overline{\pi}\), \(\overline{\pi}\)			1/1/E
4	hin 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	~	2001.7
	filed with Hygiene other the	Сош	13702 HYRS 1015 ONAL 1 AUGES		25:05	
M	a la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last)  18. Mother's Nam  18. Mother's Nam	e (First, Middle,	Maiden Surname)	
2		2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run	ral Route Numbe	r, City or Town, State, Zig	Code) 21234
2	2 HEV =		RUTH AND I ADDELLA SEC WATTHER BLVO.	APT-310	4 CARREY ()	arylano
5			1 Burial 2 Cremation 3 Removal from State Cometery crematory or other place)		20c. Location · City or To	own, State
			1 Donation 5 Other (Specify) By R.R. (2A-13)	~	The Kassot	1 JASATAVO
Ċ	Dail permit. Departr Importe eny inji		21. 3 have Fund Serves Liousese  22. Name and Address of Packing OF  EXAMPLE AND PACKETS OF  EXAMPLE A	an Pag	KNITTE (JOU	4/BDD
				or respiratory ari	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition A (111te M11) (Ard 191 TN)	rctio	N	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	rou, te be executed ysician and e burial-transit	Examiner	triat initiated events C.			
ç	fou, te be exe ysician a	cal Ex	resulting in death) Last Due to (or as a consequence of):			
ç	oo/ ifficate g phys	edic	d			
dx :	BOX 08 (1)  Beath certificate to a strength of the transfer as	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delive	ery Day Year
	the at	ysici	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown		World	Day Tour
•	cords, F.C. wrequires that the de been signed by the s should be detached	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the	ne cause of death?
7	equires en sig	ed b	Intected Suprapubic Urinary Catheter	1□Y	es 2 No 3 □ Prob	pably 4 □Unknown
	HECC e lawr has be	nple	Obstructive Chronic Kenal Failure	24a. Was a autops	sv prior to co	psy findings available mpletion of cause of
-	n: The licate l		25. Was case referred to medical 26 Place of Deat		2 □ 1 □ Yes	2 No
*: /	OI VICAL TEP Physicien: The la r this certificate has	To Be	examiner?		ence 6 □Other (Specif	y)
	ng Ph fiter th		27. Manns of Death 1 Linatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?	28d. Describe h	ow injury occurred	
	Invision of vital necords, r.O. for Attending Physicien: The law requires that the caller death. Director: After this certificate has been signed by the fin by the funeral director, page 2 should be detached.	Certification:	2 Accident investigation M 1 Yes 2 No	28f. Location (S	treet and Number or Rura	J Route Number
	DIV el or A s after f Direct	Sertil	4 Homicide determined determined building, etc. (Specify)	City or Tow	n, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit	edical (	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the c	ause(s) and manner as si late and place, and due to	lated.
	this 24	Medi	one) and manner stated.  29b. Signature and title of certifier 29c. License number		29d. Date signed (Month,	
	F 3 F 8		TIKIM, M.D. RES 0000		November,	27,2004
	1241		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		November,	h-7
	10		DR. J. KIM-900 Hranklin Square Drive-BAH 31. Date filed (Month, Day, Year) 32. Registrar's Signature	imore,	MD.212	31
	Sta Regist		DEC 0 6 2004 See 4			
	DHMH 17 Rev 1/2	001	p sparks		-	
			ORIGINAL			

State of Maryland / Department of Health and Mental Hygien 2 0 0 1

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Physician Novembe ZY, Zerry 6
ation of Deeth 4c. County of Deeth

DATIMORE ARK /Medical 4e Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location of Deeth Examiner -UTHERAN AUGS BUKG If Under 24 Hrs.
Hours Min.
8. Date of Birth
(Month Cay If Under 1 Year Months Days 7. Age (In yrs, lest birthday)
Yrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) CAROUNA **Funeral** Months 214.24.7755 Usuel Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mantel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, the Medical Evarament must be notified at 10a. Stete 10b. County 10d. Inside City Limits 10c. City, Town or Location SAUTIMORE 1 No 2 No MD Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Guban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 □ Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Cotlege (1-4or 5+) DONESTIC 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) BANTO, MO MANHOLD AVE. 20b. Plece of Disposition (Name of cemetery, crematory or other plane). Method of Disposition 12-3:04 BAUTIMORE, MARYLAND 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility VAVGHN C. GREENE FUNERAL Hm. 21. Signature of Funeral Service Licensee BATIMORE, MD 21212 KOAD 23a. Part1. Enter the disease, of implications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requiras thet the death cartificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the a completaly filled in by the funeral director, page 2 should be datached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 2010 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospitel: 1 | Inpatient 1 Yes 2√200 Other: Certification: To 2 ER/Outpatient 3 DOA 420 Jursing Home 5 Residence 6 ☐Other (Specify) 28c. Injury at Work? 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Aatural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier (Check only one) Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) B DEC 06 31. Date filed (Month, 32. Registrar's Signature State March Registrar

			1 - For State Registrar	ate of Maryland	d / Depar <i>Certi</i>	tment of H ficate of L	ealth and M Death	ental Hygiei Reg.		38441
	Physici	an	Decedent's Name (First, Middle, Last)	CLARKE				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, give street		- 4	lb. City, Town, or	Location of Death	DECOMPACE	4c. County of Deal	
	Examin	er	NONTHWEST +	Cartace	WES	RAND	Allston	200	BACTION	-6-0
	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. In		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birt	hplace (State or Foreign
	Director		212-28-5670 Usual Residence of Decedent	80	113.			02 01	24	VA
	anytan show	Ž	10a. State 10b. County		, Town or Loca					10d. Inside City Limits
	the M 28e-1	recto	MD NA  10e. Street and Number	Bal	timore	10f. Zip Code		100	Citizen of What Co	XXYes 2 □ No
	h with 23a or st be	ai Di	3800 West Belvede	re Ave Ap	t 419	212	15	109.	U.S.A	andy.
	tems terms	Funeral Director	11. Marital Status 12. W	as Decedent Ever in U.S med Forces?	S. 13. Wa	s Decedent of His	spanic Origin? (Spe n, Mexican, Puert <i>o</i> F	cify Yes or No- lican, etc.)	14. Race - Ame Black, White	
39	72 hours after death with the Maryland natural', or Items 23a or 28e-f show disal Examinat must be notified at	by	If	☐ Yes 2 ☐ No Yes, Give ear or Dates:	10	Yes 2 No	Specify:		Specify: E	lack
21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade com		16a. Deceder	nt's Usual Occupa	ition Juring most of workin	16b	. Kind of Business/	Industry
121	within iene. than "	mp	Elementary/Secondary (0-12)	ollege (1-4or 5+)	life. DO	NOT use retired)	sistant		Hospit	al
<u>1</u> 2	e filed withing Hygiene. other ther	Be Co	12th grade  17. Father's Name (First, Middle, Last)	na	NUL	Jing Ab		(First, Middle, Maid	<del>_</del>	
ylar	should be and Mental marked o	To B	Jacob Robinson				Ada Gree	ene		
Maryland	~ ~ ~ ~		19a. Informant's Name/Relationship (Type, P	•	_		nd Number or Rural  y Ave, I			Zip Code) 21215
	ges 1 and 3 it of Health If item 27 or other tra		20a. Method of Disposition	20b. PI	ace of Dispositi		Da		Location - City or	
altimore,	Page ment o ent: If ury or		1 ∑Burial 2 ☐ Cremation 3 ☐ Remov `4 ☐ Donation 5 ☐ Other (Specify)	al from State  Kin		-	ark 12/8	8/04 Ra	ndallst	own, Md
Balt	permit. Pages 1 Department of H importent: If ite any injury or ot once.		21. Signature of Funeral Service Licenseg	uonut	430 430	ShuF/H Waba	s of Facility West sn Ave,	Baltimo	re, Md	21215
			23a 11. When the disease, or complication such or heart failure. List only one cau	is that caused the death	. Do not enter t	the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Pnysician /Medical		In diate Cause (Final diate se or condition reting in death)	5	EP81	5				Onset and Death
	Examiner			Due to (or as a consequ	ienče of):					
	D #	ner	dause. Enter Undertving	Due to (or as a consequ	ience of):					
	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
68760,	ficate be executed physician and s the burial-transit	edical E	d							
_			IF FEMALE:							
Вох	death certifu e attending I ed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnar □Live birth  2 □Fetal □Pregnant at time of de	death 3 □Ed	topic pregnancy			23d. Date of deli Month	very Day Year
o.	0 0 0	hysic		Unknown	ath 5 0	ther (specify)				
s, P.	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contribut	ing to death but not resu	Iting in the unde	orlying cause give	n in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ord	requir	eted	ENDS1466 /14/10	TC DISE	455	TYPE	RCAMBIC	1 Yes	2€No 3□Pro	obably 4 Unknown
Vital Records,	0 - 9	Completed by	Hypoxic RES	pipa Com	1 4	lust		24a. Was an autopsy performed	prior to c	topsy findings available completion of cause of
ta	icien: Th certificate rector, pag	0	25. Was calle referred to médical				26. Place of Death	1 ☐ Yes 2 € 1	No 1 ☐ Yes	20 No
of V	Physicien: this certific	To B	examiner?	1 Impatient 2 L	ER/Outpatient	3 DOA Othe	r: 4 🗆 Nursing Hom	e 5 Residence	6 □Other (Spec	rify)
	ding P	ion:	1 ☑Natural 5 ☐ Pending	a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 28 ? 'es 2 □ No	8d. Describe how in	jury occurred	
Division	f or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	a. Place of Injury - At hor	me, tarm, street	2 -1 -		Bf. Location (Street		ral Route Number,
ā	ital or A	Cert	4   Hothicide	building, etc. (Specify,			Eq.	City or Town, Sta		
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: C	To the best of my know in the basis of examinati and manner stated.	vledge, death or ion and/or inves	ccurred at the time tigation, in my op	e, date and place, ar inion, death occurre	nd due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To thi within To the compli	Me	29b. Signature and title of certifier	7		29c. License	number	29d. [	Date signed (Month	, Day, Year)
			Jan Jan	1 mg		1	19502	Dec.	megen	3, 200/
	7		30. Name and address of person who complete	ed cause of death (Item	23a) (Type, Pri	nt)	Koni	400	HESper	to conto
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure /	1	FANDA	TO GOOD	nyl	TUD SUB
	Registr	ar	DLC 0 6 2004	fall gera	19	Spark	h			

		1 - For State Registrar	State of M	farylar	nd / Depa <i>Cei</i>	artme rtifica	nt of H te of L	ealth ar Death			Reg. No.	LJ LJ took	
Physici /Medie		1. Decedent's Name (First, Middle, Las  Lois J. Collin			-				2	. Date of D Month Noven	nber	26, 20	004 5:45 P
Examir		4a. Facility Name (If not institution, give Stella Maris H		7)			, Town, or imoni				4c.	County of D	eath altimore
Funeral Director		200-01-9007	x 7. A □ M 2∑ F	ige (In yrs.	last birthday) Yrs.	If Und Months	or 1 Year Days	If Under 24 Hours	Min.	Date of B (Month, D Oct 19	Day, Year)		Birthplace (State or For Country) Congia
Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD		10c. Ci	ty, Town or Lo		.timo:	re					10d. Inside City Lin
with the	Funeral Director	10e. Street and Number 413 S. Collington	Avenue			10f. Z	ip Code	1			10g. Citi	zen of What	Country?
within 72 hours after death with the Maryland ene. than natural', or itams 23a or 28a-f show the Madical Evair in er must be collined at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1  Yes 2X If Yes, Give Year or Dates		J.S. 13.		edent of Hi ecify Cuba 2X No	spanic Origin n, Mexican, F Specify:	n? (Speci Puerto Ri	fy Yes or N can, etc.)	10-	14. Race - A	merican Indian, /hite, etc. white
within 72 hours af ane. than "natural", or	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		r 5+)	16a. Dece (Give life.	kind of w DO NOT	ual Occupa ork done o use retired	luring most o )	f working			nd of Busine	
d 2 should be filed within th and Mental Hygiene. ?? is markad other than traumatic avant, the Men	To Be Co	17. Father's Name (First, Middle, Last)  Jessie Ray Bevin	s					18. Mother's	da L	ee Wa	e, <i>Maiden</i> .1rave	n	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic avant, the Marical Ever it et must be redifficated once.		19a. Informant's Name/Relationship (7 Patricia Pachilis 20a. Method of Disposition 1 Burial 2 Cremation 3	niece			Fa1	1stor			rive ]	Falls	ton, 1	e, Zip Code)  10 21047 or Town, State
permit. Per Department Important any injury once.		4 Monation 5 □ Other (Specify  21. Sgnap of Funeral Service Licental Service Licental Service Licental Service Licental Service Licental Service Licental Service Licental Service Licental Service Licental Service Licent		recto	r St	ate		s of Facility Omy Bo	ard 1201	655 W	. Ba]	timor	e Street
Physician /Medical		23a. P. 1. Enter the deas or single shown or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ne cause on each a. BREAS Due to (or a	T CAN		er the mo	de of dying	g, such as ca	rdiac or i	espiratory i	arrest,		Approximate Interval Between Onset and Death
ficate be executed with the physician and its the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cause of the Cause Cause of the Cause Cause of the Cause Cause of the Ca	Due to (or a										
The law requires that the death certificate to has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcom  1  Live birth  4  Pregnant  9  Unknown	2 Fet	al death 3	Ectopic Other (s	oregnancy					23d. Date of Month	delivery Day Year
uires that t signed by Id be detai	by	Part II. Other significant conditions co	ntributing to death	but not re	sulting in the u	nderlying	cause give	en in Part I.			tobacco u		e to the cause of death?
The lar	Completed									perf	s an opsy formed? 2 <b>X</b> No	prior	autopsy findings availa to completion of cause 1? /es 2 \( \text{No} \)
ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Lognital				045	26. Place of					
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al or Attending safter death. Il Diractor: After d in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of libuilding,	njury - At h etc. <i>(Spec</i>	nome, farm, str ify)					f. Location City or To	(Street and own, State	d Number or )	Rural Route Number,
To tha Hospital or Atwithin 24 hours after de To the Funeral Diract completely filled in by	Medical C	29a. Certifier (Check only one)  1 X Certifying Phy 2 Medical Exem		of examin									as stated. due to the cause(s)
To tha I within 2 To the I complet	M	29b. Signature and title of certifier	-				D (	137:	25		29d. Dat	e signed (Me	onth, Day, Year) 9/04
્રે St	ate	DR. TARIO MAHMO  31. Date filled (Month, Day, Year)	DD 2300 32. Begis		NEY VAI		RD.	TIMON	IUM,	MD 2	1093	4	

TOIS COLLINS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 4 38443 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 30, 2004 **Physician** Anna Do1by 8:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manor Care - Bethesda Bethesda Montgomery 8. Date of Birth (Month, Day, Year) Nov 15, 1908 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 □ XF 040-05-3306 96 Yrs. Director Connecticut Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at CT 1 X Yes 2 □ No Directo New Haven New Haven 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 339 Eastern Street 06513 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No þ 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Clerical 12 i. Pages 1 and 2 should be filed withent of Health and Mental Hygie rtant: If item 27 is marked other thiury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gabriel Sansone Josephine Antonelli 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna Birchard 9039 Sligo Creek Pkwy #801 Silver Spring MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. East Lawn Cemetery 12-3-04 East Haven, CT \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maresca & Sons Funeral Home 592 Chapel St. New Haven, C Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Acute Tubular Necrosis Physician Days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medicai ed by the attending p detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Urinary Tract Infection 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy rroad? 2X No 1 Yes 2 No 1 Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: A Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐xNo 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide ö the Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0055694 12-1-04 ess of person Impleted cause of death (Item 23a) (Type, Print) 4000 Olney-Laytonsville Rd. Olney, MD 20832 30. Name and address of pe Alok Mathur, 31. Date filed (Month DEC 0 6 2004 32. Registrar's Signature

DHMH 17 Rev 1/200

State

Registrar

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Records,

Division of Vital

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			1- For State of Maryland / Department of Health Certificate of Death		/ III to	38444
	Physic /Medi Examir	cal	JUDILY HULL SUPETHUROL	2. Date of Death Month	Day Year	3. Time of Death
	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours 6. Sex 1 Months Days Hours	or 24 Hrs. 8. Date of Birth	BALTimo	place (State or Foreign
	the Maryland r28a-f show natified at	Director	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  10c. Street and Number  10f. Zip Code	.55	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2▼No
036	hours after death with the Maryland turel, or items 23a or 28a-f show at Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 48 Divorced  1 Never Married 2 Married  3 Widowed 48 Divorced  1 Never Married 2 Married  1 Yes 2 No Specify  1 Yes 2 No Specify	rigin? (Specify Yes or No- an, Puerto Rican, etc.)	14. Race - Ameri Black, White	ican Indian,
121215-0036	d within 72 piene. r then "nei	Completed		st of working	RADSPOR	
Maryland	e d fa	To Be	~ - ~ ~ ~ ·	ner's Name (First, Middle, Main Der or Rural Route Number, Ci	B100120	p Code)
Baltimore, N	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 ie marke any njury or other treumetic once.		20a. Method of Disposition  12 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. S. nature of Fune (Specify)  22. Name and Address of Facilia	DEC 3, B	Chocation - City or T	0wn, State  14 114 10  2,834
	Pnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	s cardiac or respiratory arrest,	CRY THE !	Approximate Interval Between Onset and Death
8760,	certificate be executed and rights physician and see as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Que to (Cas a consequence II): CUXO 5 3 4 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	Canter of declen	- The	2/2 year
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Vital Record		Be Completed	25. Was case referred to medical 26. Place	24a. Was an autopsy performed 1 Yes 2754.	? prior to co death?	psy findings available mpletion of cause of 2 No
Division of V	utending Physicien: death. ctor: After this certific the funeral director.	2	27. Manner of Death 1 ★Natural 5 □ Pending 2 □ Accident   28a. Date of Injury (Month, Day Year)   28b. Time of Injury Work? 4 □ Accident   28c. Injury at Work? 5 □ Pending (Month, Day Year)   1 □ Yes 2 □	28d. Describe how in	e 6 ☐Other (Specifinjury occurred	ý)
DIVI	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	al Certification;	3 ☐ Suicide 4 ☐ Homicide  Certifying Physician: To the best of my knowledge, death occurred at the time, date an	City or Town, St	a(s) and manner as s	taled
	To the Ho within 24 h To the Fu completely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deal and manner stated.  29b. Signature and title of certifier  29c. License number	ath occurred at the time, date a	and place, and due to  Date signed (Month,	Day, Year)
	12		30. Name and address of person who completed cause of death (II) m 23a) (Type, Print)  Albert L. Blumbers www 6701 No. (Oap. d	los at Balt	ember!	21204
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 6 2004  32. Registrar's Signature	W C	1 ····································	

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			For State	State of Marylar	•	ent of Heal ate of Dea		-		nni.	381.1.5
			Registrar  1. Decedent's Name (First, Middle, Last)		Oeranoe	ile of Dei		2. Date of De.	Reg. No	004	3. Time of Death
	Physici		William L.	Engle				Decem	ber 1	2004	15:00P.M
1	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. Ci	y, Town, or Loca			4c. Cour	nty of Death	0
			942 Ellendale	Drive	In an himboland If I Inc	-	SOM Inder 24 Hrs.	8. Date of Bird	54	7777	1018 CO.
ű.	Funeral Director		5. Social Security Number 6. Sex 212-16-6332 Usual Residence of Decedent	M 2□F 7. Age (In yrs.	444		ours Min.	8. Date of Bin (Month, Da	y, Year)	Ly K	place (State or Foreign intry)
	Maryland i-f ahow lied al	tor	10a. State 10b. County Maryland Baltmi	re Co. 10c. Ci	ty, Town or Location TOWSOM						10d. Inside City Limits 1 ☐ Yes 2 No
	h with the 3a or 28s	al Director	10e. Street and Number 942 Ellenda	le Driv	10f.	Zip Code ZIZ	86		10g. Citizen o	of What Cou	untry?
980	d 2 should be filed within 72 hours after death with the Maryland in and Mental Hyglene. It is marked other than "natural", or Items 23a or 28a-f ahow traumatic event, it a Medical Examina must be outliked at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1/25 yes 2 □ No / 1/26 yes, Give Year or Dates:	4/1/	pedent of Hispan pecify Cuban, Mo 2 No Sp	nic Origin? (Spexican, Puerto	ecify Yes or No Rican, etc.)	14. P B Spec	lace - Amer lack, White city: W	nican Indian, n, etc.
Maryland 21215-0036	within 72 ho ene. than "natur ise Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	cation completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NOT	sual Occupation work done during use retired)	most of work	ing actor	16b. Kind of	Business/I	
and 2	ild be filed v lental Hygie 'ked other t ilc event, Ill	To Be Co	17. Father's Name (First, Middle, Last) HEARY SCART	Engle	2,007		Mother's Nam	e (First, Middle,	U	ame) PUM	1EC
Mary	and 2 should lealth and Men m 27 is merke her traumatic		19a. Informant's Name/Relationship (Type)	Engle	19b. Mailing Addre	ess (Street and M	Number or Rur	al Route Number			ip Code) 1D: 21286
Baltimore,	ges 1 t of H If ite or ot		20a. Method of Disposition  2 Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	(% /	Place of Disposition (Permetery, crematory, Calley Valle)	lame of r other place) V MeM G	ar. Dec	Date Zicy	71mo	n - City or T	own, State Maryland
Balti	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service License	gair, Is	Peace 232	and Address of	k Rd.	atives	Funer		remation (K
	Physician /Medical		23a. an1. 3 reer ne dise se, or complis shock, r heart ail re. List only Immediate Cause (Final disease or condition resulting in death)	Lung (a	men	ode of dying, su	ch as cardiac	or respiratory ai	rrest,		Approximate Interval Between On at and Doath
	Examiner	٦.	Sequentially list conditions	Due to (or as a consec							
	e be executed rsicien and e burial-transit	Examiner	it ally, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec							
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.O. Box	The law requires that the death certificate I ate has been signed by the attending physi page 2 should be detached for use as the I	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 Ectopic					Date of delin	very Day Year
<u>α</u>	quires that in signed b uld be deta	þ	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlyin	g cause given in	Part I.	23e. Did t			the cause of death?
of Vital Records,	: The law requir cate has been si , page 2 should	Completed						24a. Was autor perfo 1 🗆 Yes		b. Were aut prior to co death? 1 \( \sum \text{Yes}	opsy findings available ompletion of cause of
/ita	ysician: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?				Place of Deat	h (Check only o			
n of \	Phys r this rat di	on: To	1 Yes 2 No Part No No Part Natural 5 Pending	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	DOA Other: 4 28c. Injury at Work?	☐ Nursing Ho	eme 5 A esi 28d. Describe I	dence 6 🗆 0 how injury occ		ify)
Division	l or Attendi after death. Director: A i in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact fy)	1 🗌 Yes	2 🗆 No	28f. Location (S City or Tox		mber or Rui	ral Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical Ce	29a. Certifier 1 Certifying Physical Examination (Check only one)	sician: To the best of my knoter: On the basis of examinating and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, do	ate and place, n, death occur	and due to the red at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and the of certifier	(amo W	0	29c. License nur	nber Z 405		29d. Date sig		Day, Year)
	1701		30. Name and address of person who co		m 23a) (Typę, Print)		ntVa		mo	210	3/
		ate	31. Date filed (Month, Day, Year) DEC 0.6 20	32 Registrar's Sign.		/					
	Regist	rar	BEC 0.6 5	194 Masam	9	Ann N.	1				

Catherine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie of All

	1 - State Registrar	,	Certificate of Death	Reg	2004 3844b
Physician	1. Decedent's Name (First, Middle,	Last)		2. Date of Death Month	Day Year 3. Time of Death
Physician /Medical	CATHERIA	E CECELIA	FERNANDEZ	December	2 2004 8:78 PM
Examiner	4a. Facility Name (If not institution,		4b. City, Town, or Location of	f Death	4c. County of Death
	Franklin Squis, Social Security Number	are Hospita  3. Sex 7. Age (In yrs-h		24 Hrs. 8 Date of Birth	BCI +1 111 C TE  9. Birthplace (State or Foreign
Funeral Director	212-22-5290	1□M 2 <b>K</b> F	Yrs. Months Days Hours	Min. 8. Date of Birth (Month, Day, Y	1924 MARYLANI
pu s	Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Location	/	10d. Inside City Limits
with the Maryland e or 28e-f show be notified at	MARNIANO BOL		Pragu	Hall	1 ☐ Yes 2 No
p or 28e-f s be notified Director	10e. Street and Number	TIMORE	10f. Zip Code	11/4/	J. Citizen of What Country?
23e on	3869-6	SCHROEDE	RAVE 21	128	USA.
omer must Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		gin? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.
If item 27 is marked other then "natural", or Items 23e or 28e-f show or other treumetic event, the Medical Examiner must be notified at or other treumetic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced		1 ☐ Yes 2 🗖 No Specify:	,	Specify:
is marked other then "natural", or Items eumetic event, the Modeal Examiner or To Be Completed by Funer	15. Decedent's		16a. Decedent's Usual Occupation	16	Sb. Kind of Business/Industry
ner then "naturality in the Medical E	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+)	(Give kind of work done during most life. DO NOT use retired)	of working	
Com	12 +HGRADE	30110g0 (1 401 37)	HOMEMA	KER	OWN HOME
even Be	17. Father's Name (First, Middle, L		- 1	r's Name (First, Middle, Ma	iden Sumame)
To	19a. Informant's Name/Relationsh		FUTION CA	-THERINE	DUVALLE
treur	CLARENCE FER		19b. Mailing Address (Street and Number		O DOTAL DESCRIPTION OF THE PARTY
other	20a. Method of Disposition	20b. Pl	ace of Disposition (Name of metery, crematory or other place)		ERRY HALL MD 2112 c. Location - City or Town, State
ry or	1 ☐ Burial 2 ⚠ Cremation 1 ☐ Donation 5 ☐ Other (Sp	3   Hemoval from State	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	2-18-04 V	BALTIMORE, MARYLAN
Importent: If item 27 any injury or other tr <u>2005e</u> .	21. Signature of Funeral Service L				. FUNERAL HOME
Importer any inju QDCS.	1 Dietree	AN. Willia	M 2145 N. FUZ	TON AVE.	BALTO. MD. 21217
	23a. Part1. Enter the disease, or on shock, or heart failure. List of	omplications that caused the death nly one cause on each line.	Do not enter the mode of dying, such as		t, Approximate Interval Between
cian	Immediate Cause (Final disease or condition	- Cerebro	1 Ischemia		Onset and Death Seconds
dical liner	resulting in death)	Due to (or as a consequ	ence of):		
	Sequentially list conditions,	b. Arterios		ease	years
ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,		
rial-tra	resulting in death) Last	c. Due to (or as a consequ	ence of):		
lcal		d			
as the burial-transit  Medical Examir	IF FEMALE:				
	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
ched f	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	ath 5 Other (specify)		
cate has been signed by the attendir, page 2 should be detached for use Completed by Physician/N	Part II. Other significant condition	s contributing to death but not resu	ting in the underlying cause given in Part I.	23e. Did tobad	cco use contribute to the cause of death?
uid be				1 □ Yes	2 No 3 Probably 4 Unknown
2 sho				24a. Was an	24b. Were autopsy findings available
ate has page 2				autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1 \sum Yes 2 \sum No
certificate harector, page	25. Was case referred to medical examiner?		26. Place	of Death (Check only one)	
SE E	1 Tes 2 No			rsing Home 5 Residence	
ctor: After this y the funeral dir fication; To	27. Manner of Death  1 17 Natural 5 ☐ Pending 2 ☐ Accident investige	(Month, Day Year)	28b. Time of 28c. Injury at Work?  M 1 □ Yes 2 □ N	28d. Describe how	injury occurred
y the	3 ☐ Suicide 6 ☐ Could no	ot be	ne, farm, street, factory, office		et and Number or Rural Route Number,
ed in by the funeral Certification;	4 Homicide	building, etc. (Specify,	, , , , , , , , , , , , , , , , , , , ,	City or Town, S	
y fille	29a. Certifier 1 Certifying	Physician: To the best of my know	rledge, death occurred at the time, date and	place, and due to the caus	se(s) and manner as stated.
To the Funeral Director: A completely filled in by the fu	one)	and manner stated.	on and/or investigation, in my opinion, deat		
2 0 2	29b. Signature and title of certifier	Mr. MD	29c. License number		. Date signed (Month, Day, Year)
<b>N</b> -	P (	JW\	D54725		12/2/04
19	1	ho completed cause of death (Item	23a) (Type, Print)	'	210 212 2
State	31. Date filed (Month, Day, Year)	32. Registrar's Signati	inklin Square Dr	TIVE, DOUTTIM	INTE, 111 21231

DHMH 17 Rev 1/2001

State

Registrar

DEC 0 6 2004

	hysicia Medic/		1. Decedent's Name (First, Middle, Last	<b>1 #18 PER</b> FIEL	DS				2. Date of Do Month 11- 30	Dav	Year	3. Time of Death 14:19 M
	/iviedic Examin		4a. Facility Name (If not institution, give			4b. City, T	own, or Lo	cation of De	ath	4c. Coun	ty of Death	
			BAYVIEW HOSPITAL					TIMORE			N,	/A
	uneral rector		334 72 0104	7. Age (II	9 Yrs. last birthday)	If Under 1 Months		Under 24 H Hours Mi		rth ay, Year) -1944	9. Birthp Cour	place (State or Foreign ntry) CA
land	A II		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation					1	Od. Inside City Limits
Mary	H P	tor	MD BALTIMOR	RE	DUNDAL	К						1 Yes 2 □ No
th the	or 286	)irec	10e. Street and Number		20112111	10f. Zip C		0.0		10g. Citizen o		ntry?
ath w	123a	ral	2931 CORNWALL ROA				212				USA	
72 hours after death with the Maryland	item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Medical Exactinational be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 2 No If Yes, Give Year or Dates:		Was Decede f Yes, specif l ☐ Yes 2	_	anic Origin? Mexican, Pu Specify:	(Specify Yes or Nearto Rican, etc.)		ace - Americ lack, White, sify: $BLA$	etc.
72 ho	lical	eted	15. Decedent's Edi (Specify only highest grad		16a. Deced	lent's Usual kind of work	Occupatio	n ina most of w	orkina	16b. Kind of	Business/in	dustry
d within giene.	han e Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				ing most of w	·······g	EDUCAM	OD	
filed withi Hygiene.	ther t		17. Father's Name (First, Middle, Last)	5+	SPIR	ITUAL			ame (First, Middle	EDUCAT		
ould be Mental	ked o	To Be	RUSSELL WEATHERS						LIE MILI	מפו		MILLER
id 2 should be fill th and Mental Hy	s mar umat	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailir	g Address (	Street and	Number or	Rural Route Numb			
1 and 2 Health a	n 27 ls		LARRY FIELDS/HUSE	AND	29 20b. Place of Dispo	31 CO	NWAL	I. ROAD	DUNDAT	K. MD 2	1222	
of He	If iten		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ I		cemetery, cren	natory or oth	er place)	- 1	DUNDAL Date			
. Pag tment	tant:		' 4 □ Donation 5 □ Other (Specify,	)		CREM			/03/04	BALTIM		
permit. Pages 1 a Department of He	Important: If item any injury or othe once.		21. Signature of Funeral Service Licens  A.  23a. Part1. Enter the disease, or comp	with		1701 I	AURE	NS STR	EET, BAL	TO., MD	& SON 2121	S F.H., INC 7 Approximate
/Mo Exa	sician and edical the parial-transit	ıl Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a DILATE		2D10	MΥ	0P-1	THY			Interval Between Onset and Death
death certificate be executed	ed by the attending physicia detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death 3	Ectopic pred					Pate of deliver	ery Day Year
) e	sign d b	þ	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	nderlying cau	ise given ii	n Part I.		tobacco use co Yes 2 No		ne cause of death?
quires that the d	0 0	Completed							24a. Was auto perfe		prior to cor death?	psy findings available appletion of cause of
The faw requires	ate has page 2	3										
The taw requires	ate has page 2	Be	25. Was case referred to medical examiner?	Hospital:	1/		Othor		eath (Check only			
ling Physician: The law requires	After this certificate has funeral director, page 2	To Be	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1  Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury		Other: c. Injury at Work?	4 🗌 Nursing	Home 5 ☐ Res		-	v)
ling Physician: The law requires	After this certificate has funeral director, page 2	o Be	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	28b. Time of Injury  At home, farm, str	286 M	Other: c. Injury at Work? 1  Yes	4 🗌 Nursing	Home 5 Res	dence 6 00 how injury occu	ırred	v) Il Route Number,
ling Physician: The law requires	After this certificate has funeral director, page 2	Certification; To Be	examiner?  1	28a. Date of Injury (Month, Day Ye	28b. Time of Injury  At home, farm, stropecify)  y knowledge, death amination and/or inv	M set, factory,	Other: c. Injury at Work? 1  Yes office	4 Nursing 2 No	Home 5 Res 28d. Describe 28f. Location ( City or To	dence 6 O how injury occu Street and Nun wn, State) cause(s) and n	nber or Rura	Il Route Number,
ling Physician: The law requires	fter this certificate has ineral director, page 2	To Be	examiner?  1	28a. Date of Injury (Month, Day Ye  28e. Place of Injury building, etc. (Section: To the best of miner: On the basis of examiner:	28b. Time of Injury  At home, farm, stropecify)  y knowledge, death amination and/or inv	M  eet, factory,  o occurred at restigation, in	Other: c. Injury at Work? 1  Yes office	4 Nursing 2 No date and pla on, death oc	Home 5 Resing Resident Residen	dence 6 O how injury occu Street and Nun wn, State)  cause(s) and n date and place	nber or Rura manner as st a, and due to ed (Month,	ated. the cause(s)  Day, Year)
ling Physician: The law requires	After this certificate has funeral director, page 2	Certification; To Be	examiner?  1	28a. Date of Injury (Month, Day Ye  28e. Place of Injury building, etc. (Section: To the best of miner: On the basis of examiner:	28b. Time of Injury  At home, farm, stropecify)  y knowledge, death amination and/or inv	M  eet, factory,  o occurred at restigation, in	Other:  Injury at Work?  I Yes  office  the time, or my opinion	4 Nursing 2 No date and pla on, death oc	Home 5 Resing Resident Residen	dence 6 O how injury occu Street and Nun wn, State)  cause(s) and n date and place	nber or Rura manner as st a, and due to ed (Month,	al Route Number, lated. the cause(s)

DHMH 17 Rev 1/2001

=itzgerald, Cecella

			•	1 - For State Registrar	State of Maryland		ment of He			ene 0 (	) 4	38449
		_0		Decedent's Name (First, Middle, Last)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Death Month		Year	3. Time of Death
		Physicia /Medic			NARD		FRIE		Novemt	ER 30	Zac	15:58pm
		Examin	er	4a. Facility Name (If not institution, give stre	eet and number)	41	o. City, Town, or I	ocation of Death	e	4c. County	of Death	N/A
II.		Funeral Director		5. Social Security Number 6. Sex 1 No. 1 N	7. Age (In yrs. la 85		Under 1 Year onths Days	Hours Min.	8. Date of Birth DEC. 9,19	T8	9. Birth Cou	place (State or Foreign intry) MD
•		ō.		Usual Residence of Decedent		Townstand						101 1-11-01-11-1
3		ahow	'n	10a. State 10b. County	10c. City,	Town or Locati		BALTIMORE	=			10d. Inside City Limits 1
d		the N	Funeral Director	MD N/A  10e. Street and Number			10f. Zip Code	DALTINORI		g. Citizen of W	/hat Cou	
70		h with	ai Di	2701 JEREMY COURT	#C			21209				USA
eonal		r deat	ner	11. Marital Status	. Was Decedent Ever in U.S Armed Forces?	i. 13. Was	Decedent of His	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No- Rican, etc.)		Amer k, White	ican Indian, , etc.
3	920	I within 72 hours after death with the Maryland liene. I than "natural", or Items 23a or 28a-f ahow I ta Medical Exactiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No WW If Yes, Give Year or Dates: ARI		Yes 2∏ No	Specify:		Specify	:	WHITE
()	2-003e	72 ho	eted	15. Decedent's Educa (Specify only highest grade of	tion	16a. Decedent	's Usual Occupat d of work done du	tion uring most of work	ing 1	6b. Kind of Bu	siness/l	ndustry
	121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	BARTENI	NOT use retired) }FR			ENTERT	ATN	MFNT
	5	filed Hygi Hygi ant, I	Be Co	17. Father's Name (First, Middle, Last)		DARTER		18. Mother's Name	e (First, Middle, M			
L.	ylar	Q 20 00	To B	ABRAHAM		FRIED		ANNA				ERWITZ
	-	s 1 and 2 should if Health and Men itam 27 la marke other traumatic		HOWARD FRIED / SO		_			- CHAPEL	•		
		s 1 and 2 f Health itam 27 other tra		20a. Method of Disposition	20b. Pla	ace of Disposition		; .		Oc. Location -		
	altimore,	Pages nent of ant: If it ury or o		1 D Burial 2 □ Cremation 3 □ Rer '4 □ Dopation 5 □ Other (Specify)	noval from State	S MONTE	FIORE W	OODMOOR :	12/3/2004			IMORE, MD
	Balt	permit. Page Department i Important: If any injury o		21. Simplify of Funeral Service Line Asse	11101				_ LEVINS( ROAD - Pi			, INC. MD 21208
				23a. Pan1. Enter the disease, or complica shock, or heart failure. List only one	ations that caused the death.	Do not enter t	he mode of dying	, such as cardiac o	or respiratory arres		,	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	Acute	Rena	1 +A	11/2	9			Onset and Death
		/Medical Examiner		resulting in death)	Due to (or as a consequent	ence of):						
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X		acuted and transit	Examine	Cause (Dispare of Injury) that initiated events resulting in death) Last								
	8760,	cate be executed physician and the burial-transif	al Ey	1930king in dodaii) Last	Due to (or as a consequ	ence or):						
		ificate g phys as the	edical	d						1		
	Вох	leath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	E. If yes, outcome of pregnar	death 3 □Ec	topic pregnancy			23d. Date Mor		very Day Year
	o.	at the de by the a stached a	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	atti 5 🗆 O	ther (specify)					
	Division of Vital Records, P.O. Box	as the gned	by	Part II. Other significant conditions contr	ibuting to death but not result	Iting in the unde	rlying cause give	n in Part I.				the cause of death?
	COL	w require been sij should t	ietec	congestive	east Dis	easE			24a. Was an	24b. V	Vere aut	opsy findings available
1	Re	sician: The law s certificate has b lirector, page 2 s	Completed		,			-	autopsy perform	ed? d	rior to c	ompletion of cause of
	ita	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical examiner?					(Check only one			
,	of <	Physic this or	은	1 ☐ Yes 2 No		P/Outpatient 28b. Time of	3 DOA Other	4   Nursing Ho	me 5 Resider 28d. Describe hov			ify)
	ono	iding Phys th. : After this i funeral di	tion	Natural 5 Pending	(Month, Day Year)	Injury	28c. Injury Work' M 1 □ Y	es 2 □No	200. Describe not	v injury occurr	50	
	Visi	after death after death Diractor: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street	factory, office		28f. Location (Stre City or Town,		er or Rui	ral Route Number,
	Ö	urs after iral Dirac										×
		To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my know pr: On the basis of examinati and manner stated.	viedge, death or on and/or inves	curred at the timi tigation, in my op	e, date and place, inion, death occurr	and due to the car ed at the time, da	use(s) and ma te and place, a	nner as ind due	stated. to the cause(s)
		To the To the Comp	M	29b. Signature and title of certifier	laucie in	0.1	29c. License	number	29	d. Date signed	(Month	, Day, Year)
	•	0,0		TO OF F	ipleted cause of death (Item	23a) /Tuna Dai	1000	3 ( 2 ) 8	N	svem t	7-C(15	_ )0,2009
		110		30. Name of address of person his com	hysiciA ipleted cause of death (Item & T2 MD 2 U 32. Registrar's Signate	COL W.	Belveder	Le Ave	BAITIN	nore	m	021215
	:	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	1					
	No.	Registr	ar	DEC 0 6 2004	Magasin	P	sports	A				

DHMH 17 Rev 1/2001

			1 - For State Registrar		State of N	Marylan		artmen rtificate				ental Hy	giene		4	38450	
	Physici	an	1. Decedent's Name (First, Mi	ddle, Last)								2. Date of De Month	eath Dav	, Y	ear	3. Time of Death	
	/Medic			Grant	Gar						-	Novemb				4:00P M	
4	Examir	er	4a. Facility Name (If not institu			r)		4b. City,	Town, or	Location	of Death			County of			
			Holy Cross Ho  5. Social Security Number	spita 6. Sex		Age (In yrs. i	last hirthday)	Silv If Under		pring If Under		8. Date of Bi		ntgom		non (State or Foreign	_
	Funeral Director		230-50-6086 Usual Residence of Decedent		4 2□F	64	Yrs.	Months	Days	Hours	Min.	Nov. 1	av. Year)			ace (State or Foreign try) Sinia	_
	land ow		10a. State 10b. Cou	nty		10c. City	, Town or Lo	ocation							10	Od. Inside City Limits	
	Mary -1 sh	tor	Texas Bexa	r		Sar	n Anto	nio							ŀ	1 XYes 2 No	
	r 28e	irec	10e. Street and Number			Dai	111160	10f. Zip	Code	1			10g. Cit	izen of Wha	at Coun	try?	_
	h with	al D	4111 Medical I	r., Aı	ot. B-2	04		78:	222				U.S	.A.			
	ems ermi	ner	11. Marital Status		. Was Deceder Armed Force	nt Ever in U.	S. 13.	Was Deced	lent of Hi	spanic Ori	igin? (Spe	cify Yes or N Rican, etc.)	0-	14. Race - Black,			
36	72 hours after death with the Maryland naturel', or items 23s or 28e-f show isos Examinar must be notified at	by Funeral Director	1 Never Married 2 1		1 Tes 2	∑ No		1 ☐ Yes 2						Specify:			
Ö	turel'		3 Widowed 4 Divor		Year or Dates	š:	162 Doco	dent's Usua	I Occupa	tion			16h K	ind of Busir		Black	_
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212	iene.	E	Elementary/Secondary (0-1	2)	College (1-4d	r 5+)		ctrica					Au	tomob	ile		
þ	e filed I Hyg othe	Be C	17. Father's Name (First, Mide	ile, Last)						18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)			
<u>lar</u>	Alenta Alenta rked ritic e	To E	Unknown							Mary	7 Gar	ner					
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene the Health and Mental Hygiene flem 27 is marked other then "naturel", or tiems 23a or 28e-1 show other treumatic event, The Medical Examinar must be notified at		19a. Informant's Name/Relati				19b. Maili	ng Address	(Street a	ind Numbe	er or Rura	l Route Numb	er, City o	r Town, Sta	ate, Zip	Code)	
≥,	and salth m 27		Johnetta G.	Davis	(Siste		-			., NW		hingto					
ore	iges 1 it of H if Iten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati	on 3 ⊡Ren	noval from Sta	te C	lace of Dispo emetery, crea	matory`or o	ther place	1		ate	20c. Lo	cation - Cit	y or To	wn, State	
E.	Pag tment tent: lury o		' 4 □ Donation 5 □ Othe	(Specify)		War	rento				.2/4/					'irginia	
Baltimore,	permit, Pages Department of the Importent: If Ite any injury or or once.		21. Signature of Funeral Serv	Licensee	estel	te	7	2. Name an	d Addres	s of Facili	V2-03-03-0	nes Fu . Box				on, VA 2018	38
	Physician Indicate be executed Indicated by sician and Indicated as the purial-transit	dical Examiner	shock, or left ta fur. Immediate Car e (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Jease) of hur that initiated events resulting in death) Last	a	Multi Due to (or a		reloma									Interval Between Onset and Death	
B.	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	230	c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3[	Ectopic pro						23d. Date o Month		ry Day Year	
	w requires that the been signed by th should be detache	by	Part II. Other significant con	ditions contri	ibuting to death	but not resu	ulting in the u	nderlying ca	ause give	en in Part I	,					e cause of death? ably 4 XUnknown	
Vital Records,	has b	Completed										24a. Was auto perf 1 Yes		prio	r to con th?	sy findings available appletion of cause of	
ta	ilcian: Th certificate rector, pag	a	25. Was case referred to med	lical						26. Place	of Death	(Check only		1 10	103	20140	-
	y si	To B	examiner? 1 ☐ Yes 2 🛣 No	Hos	spital:	tient 2 🗆	ER/Outpatier	nt 3 DO	A Othe	er: 4 🗆 Nu	ursing Hor	ne 5□Res	idence	6 Other	(Specify	)	
		ü	27. Manner of Death 1 XNatural 5 ☐ Pe	nding	28a. Date of Ir (Month, I	njury Day Year)	28b. Time o	f 2	8c. Injury Work	at ?		8d. Describe					
Ö	Attending r death. ector: Afte oy the fune	satic	2 Accident inv	estigation				M		res 2□	No						
Division	or Att	Certification:		ald not be	28e. Place of building,	Injury - At ho etc. (Specif)	me, farm, sti	reet, factory	, office		2	281. Location City or To	Street and	d Number (	or Rurai	Route Number,	
	urs a	Ce	00- 0-4 <sup>2</sup>	full of the state	<u> </u>						- 11						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medi	cal Examine	r: On the bears and manner	of examinat	wledge, deat tion and/or in	h occurred vestigation,	at the tim , in my op	e, date ar pinion, dea	nd place, a ath occurre	and due to the	dato and	l place, and	due to	the cause(s)	
	To To E	Σ	29b. Signature and title of cer	tifier ^	-	K				number				e signed (A			
	In		Mun	10-	~ \				D006	1595			Nov	ember	25,	2004	
/	CY		30. Name and address of per	/					D 4	C 4 1	1702	Sprine	MT	20014	า		
1	1		Marjorie A. 31. Date filed (Month, Day, Y		t, MD,	strar's Signa		етеп	ĸu.	, 511	rver	Phring	, FID	2031			4
`	Sta Regist	ate rar		6 200		strains signa	- 1	1	sour	2							

			1 - For State Registrer	State of M	laryland / De	epartment of F Certificate of	lealth and Death		giene 004	38451
	Physici /Medio	al	1. Decedent's Name (First, Middle,	V	SOLD			2. Date of Dea Month NOVE HBE	R 27 Zac	410:00 + M
<i>k</i>	Examir	er	4a. Fecility Name (If not institution, g Hebrew Home of  5. Social Security Number 6	Greater Wa		4b. City, Town, o	11e	Irs. 8 Date of Birth	4c. County of De	ery
	Funeral Director		120-18-6417 Usuel Residence of Decedent	1 <u>M</u> M 2□F	83 Yrs	Months Days	Hours M	in. (Month Day April 2	20°, 1921	rthplace (State or Foreign Jountry) New York
	a-f show	tor	MD 10b. County MD Montg	omery	10c. City, Town o					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
1	3a or 28	al Director	10e. Street and Number 6121 Montrose R	load		10f. Zip Code	852	1	Og. Citizen of What C	Country?
036	and Mental Hygione. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, tre Medical Exact or than Le traitified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 XYes 2 If Yes, Give Year or Dates:	t Ever in U.S. ? !No 1943 to 1945	I3. Was Decedent of I- If Yes, specify Cub	Hispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:	
Baltimore, Maryland 21215-0036	iene. rthan "natur the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education	16a. De	ecedent's Usual Occupion of work done e. DO NOT use retire	during most of	working	16b. Kind of Busines:	s/Industry
yland	Mental Hyg Merked other latic svent,	To Be C	17. Father's Name (First, Middle, La Emil M. Goldbla	st) tt			Ruth	lame (First, Middle, I McNichola	Maiden Sumame) S	
ore, Mar	Health Health em 27 ther tr		19a. Informant's Name/Relationship  Susan J. Wolk —  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3	Daughter	20b. Place of Di		rook Tei	race Poto	mac, MD 20 20c. Location - City o	854
Baltimo	Department of Important: If its sny injury or o		*4 Donation 5 Other (Spe 21. Signatury of Funeral Service Lie	city)	Cedar I	1111 Cemete 22. Name and Addre Smith, Sea	ss of Facility	2-1-04 Quackenbus	h. Inc.	ppe, New York
	hysician	4	23a. Part   Enter the disease, or co shock, or heart failure. List on immediate Cause (Final disease or condition	mplications that cause by one cause on each l	d the death. Do not ine.	117 Maple enter the mode of dyir	ng, such as card	iac or respiratory arm	10950 est,	Approximate Interval Between Onset and Death
E	/Medical ixaminer	ılner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. DE	a consequence of):	TIM				
8760,	ohysicien and the burial-transit	dicai Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
Records, P.O. Box 68760,	by the attending parached for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	1		23d. Date of de Month	livery Day Year
rds, P.	been signed by	by	Part II. Other significant conditions	ontributing to death by NTEGTII	out not resulting in th	e underlying cause giv	en in Part I		pacco use contribute t	o the cause of death?
		Completed						24a. Was ar autops perforn 1 Yes 2	24b. Were a prior to death?	utopsy findings available completion of cause of
0	After this funeral di	ertification; To Be	25. Was case referred to medical examiner?  1   Yes   2   No  27. Manner of Death   Valuatural   5   Pending   2   Accident investigat		ury 28b. Tim	e of 28c. Injur	er: 4 Nursing	Home 5 Reside 28d. Describe ho	nce 6 Other (Spe	rcify)
DIVISION	within 24 hours after death To the Funeral Director: completely filled in by the	OF	3 ☐ Suicide 6 ☐ Could not determine	building, et	tc. (Specify)	street, factory, office		City or Town		
ed ed	within 24 hours a To the Funeral I completely filled	Medical	one)	Physician: To the best aminer: On the basis of and manner st	of examination and/o	investigation, in my o	pinion, death oc	curred at the time, da	ite and place, and due	e to the cause(s)
) -	00 2 M		29b. Signature and title of certifier	Kuli	rang M	D. D. 3	9543	6 N	OUE MISER	n, Day, Year) 28, 2004 1) 20852
	\)	10	30/Name and address of person who have by ARP ARP ARP ARE ARE ARE ARE ARE ARE AREA AREA	ALGAZNY 32 Parish	death (Ifem 23a) (Tyl	Paut ROS	E RUHL	D, ROSKU	MUE, M	020852
~ 16-	Sta Registr		DEC A.R	2004 32	mere 1	g Span	2			

			1 - For State Registrar	State of Marylar	nd / Depa <i>Cer</i>	rtment of H	lealth a	ind Mer		jiene ()	04	384	52
			Decedent's Name (First, Middle, Last	st)					Date of Dea	th		3. Time of	Death
	Physicia /Medic		James				ricer		Month ecent	Day	Year	18:4	OPM
	Examin		4a. Facility Name (If not institution, give	street and number)	. 1	4b. City, Town, o	r Location of	f Death	0.1		nty of Death		
		1.5	The Johns F	opkins HO	80Hal	f Under 1 Year	If Under 2	-	14Y	N/			
	Funeral Director		5. Social Security Number 6. S 212–42–0918	9x 7. Age (In yrs. ▼ M 2□F 61	Yrs.	Months Days	Hours	Min.	Date of Birth Month, Day 7-9-4	Year)	9. Birth	place (State o ntry) N.C.	
			Usual Residence of Decedent				<u> </u>		, , ,			14.0.	
	how		10a. State 10b. County	10c. Ci	ty, Town or Loc							10d. Inside Cit	•
	Ba-fs	Director	Md. NA		Baltim							1 <b>2</b> Yes	2   No
	with th		10e. Street and Number 118 N. Maderia S	Street		10f. Zip Code	.231		1	0g. Citizen o	f What Cou	ntry?	
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U	I.S. 13. V	/as Decedent of H	Hispanic Orig	in? (Specify	Yes or No-		ace - Americ	can Indian,	
9	be filed within 72 hours after death with the Maryland hal hygiene. id other than "natural", or itams 23a or 28a-f show other than "natural", or itams 23a or 28a-f show evant. The Medical Examinator must be notified at		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ▼No	lf lf	Yes, specify Cub	an, Mexican,	, Puerto Rica	ın, etc.)		lack, White,		
003	ural',	d by	3 ☐ Widowed 4 🌠 Divorced	If Yes, Give Year or Dates:		☐ Yes 2 💢 No	Specify:			Spec	illy: Dic	ack	
15-(	"natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	ent's Usual Occup kind of work done O NOT use retire	during most	of working		16b. Kind of	Business/In	dustry	
12	within lene. than "u	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)		nitation				Balt	imore	City	
ld 2	e filed within al Hygiene. I other than ' vant, the we	Be C	17. Father's Name (First, Middle, Last)				18. Mother	r's Name (Fi	rst, Middle,	Maiden Suma	am <i>e)</i>		
/lar	2 should be a and Mental is marked o	To B	Lee	Arthur	Brown		Mai	mie			Gree	ene	
Maryland 21215-0036	2 sho and ia ma		19a. Informant's Name/Relationship (			Address (Street						. *	7. T
	ges 1 and 2 should it of Health and Men it Itam 27 ia marke or othar traumatic		Joyce Greene  20a. Method of Disposition	Sister	-	Seagull		Dalti		20c. Location		Apt.	H—I
altimore,	permit. Pages Department of I Important: If Its any injury or of		1 Surial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specifi	nemoval nom State	cemetery, crem odlawn	ition (Name of atory or other place	1	12-6-0			more,		
Ħ	nit. P artme ortan injur.		21. Signature of Funeral Service Licer	129		Name and Addre				timore		21202	
ñ	Depa impo any ii		) Francis	MARK	N	March F.H	H. Eas	t l	.101 E	. Nort	h Ave		_
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused the deal	n. Do not ente	r the mode of dyir	ng, such as o	cardiac or re	spiratory arr	est,		Approximate Interval Bety	veen
	Physician		Immediate Cause (Final disease or condition	a. Preum	onia						~	Onset and E	
	/Medical Examiner		resulting in death)	Due to (or as a consec									,
		<u>-</u>	Sequentially list conditions,	b. CW/OALC  Due to (or as a consec		1098700	12 (	reunce	m.c			3 mant	~S
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate causes. The court of the cause (Disease or injury that initiated events		,								
o,	exect an and rial-tra	Еха	resulting in death) Last	Due to (or as a consec	juence of):								
8760,	cate be executed physician and the burial-transit	dlcai		. d									
9	ertifica ling pt e as t	0	IF FEMALE:										
Вох	death certifi e attending ad for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnant 1 Live birth 2 Feta	il death 3 🗌	Ectopic pregnancy	/				ate of delive Nonth	•	ear
o.	the che	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of c 9□Unknown	ieatn 5□	Other (specify) _							
<u>a</u>	es that gned by be deta	by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the un	derlying cause giv	en in Part I.		23e. Did tol	oacco use co	ntribute to t	he cause of de	eath?
Records,	- W D								1 □ Ye	s 2□No	3 🗌 Prot	oably 4 🖄	nknown
eco	e law requ has been ye 2 shoul	Completed							24a. Was a		. Were auto	psy findings a mpletion of ca	ivailable
Œ	Th ate pag	Com							perform	ned? 2 □ No	death? 1 ☐ Yes		
Vital	ysician: Th	Be	25. Was case referred to medical examiner?	He saikel.		0.11		of Death (Cl	neck only on	e)			
of	S 5 5	. To	1 ☐ Yes 2 ☑ No  27. Manner of Death	Hospital: 1 Anpatient 2 2	ER/Outpatient 28b. Time of	3☐ DOA Oth 28c. Injur	4   Nur			ence 6 🗆 O		(y)	
	ding th. After fune	tlon	1 Accident 5 Pending investigation	(Month, Day Year)	Injury	Wor	k? Yes 2□N		Describe IIC	w injury occi	III		
Division	Attending It death. actor: After by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, stre	et, factory, office					nber or Aura	al Route Numb	per,
Ö	tal or A s after al Dira ed in b	Cert	4 - Houneige	building, etc. (Special	у)				City or Towr	i, State)			
	To tha Hospital or Attending Ph within 24 hours after death. To tha Funeral Diractor: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the tirestigation, in my o	ne, date and pinion, death	place, and h occurred a	due to the ca t the time, da	ause(s) and nate and place	nanner as si	tated. the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number		2	9d. Date sign	ed (Month,	Day, Year)	
}	1		Munch	ience.		1265-	000		D	ecem	رو ١	2004	
	L		30. Name and address of person who		n 23a) (Туре, F	Print) JUHNS	HOP	ICINS	11 02 17	IMC		, 000	
	v ¬)		600 WORTH WOL	FE STREET, B	MITJA		MARL	1. CANY	) 2	1128	+		
	Sta Registr		31. Date filed (Month DEC ear)	32. Registrar's Signa		Spor	KN						

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		1 - For Stete Registrar		Olato o	Marylan	•	tificate of		na monta	Reg.	/ 11 11 13	38453
9		1. Decedent's Nam	e (First, Middle,	Last)	/ .				2. Date Mont	of Death		3. Time of Death
Physic /Med		DENN	15 (	0LD51	EIN				12	0	Day Year	10:42A M
Exam				give street and nur			4b. City, Town,	or Location of	Death		4c. County of Deat	th
_		11530 5. Social Security N		Patuxer 6. Sex	nt Pkwy 7. Age (In yrs. I		Columb If Under 1 Year		4 Hrs. 9 Date	of Rirth	Howar	
Funera Directo		215-48-		XXM 2□F	7. Age (iii yis. i	Yrs.	Months Days			of Birth th, Day, Ye t 12,		hplace (State or Foreign ountry) V York
D		Usual Residence of	f Decedent						Augus	14	1340   Nev	
arylar show	-	10a. State	10b. County	a		, Town or Lo						10d. Inside City Limits 1 ☐ Yes ※※※ No
the M	Director	MD 10e. Street and Nu	Howar	<u> </u>	Co.	lumbia	10f. Zip Code			100	Citizen of What Co	
Mith 3a or	Ö					<b>#202</b>	21044			, og.		, and y
death	Funeral	11. Marital Status	ittle	Patuxent 12. Was Dece Armed Fo	dent Ever in U.	, # 2 0 3 S.   13. )	Was Decedent of f Yes, specify Cut	Hispanic Origi	in? (Specify Yes	or No-	USA 14. Race - Ame	
after or its			ried 2 Marrie			İ	1 ⊡ Yes <b>XIX</b> No		ruento Aican, et	G.)	Specify: Wh	
IL LISTONOSO filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or items 23e or 28e-1 show ent, ITE Markeal Examiner must be mailfied at	d by	3 Widowed		Year or D	ates:					166		
in 72	Completed			t grade completed)		(Give	tent's Usual Occu kind of work done DO NOT use retire	during most of	of working	100	. Kind of Business/	industry
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ba filed that Hyge dother avent,	BeC	17. Father's Name	(First, Middle, L	.ast)					's Name (First, A	fiddle, Maid	den Sumame)	
yid ould b Ment Parked	2	George						_	ia Levy	•		
VICE 12 shd h and 7 is m	4	19a. Informant's N									ty or Town, State, 2	
If E, INIAL YIATIO Z IZIO-0000  I and 2 should be filed within 72 hours after death with the Marylan fileath and Mental Hygiene. If Heath and Mental Hygiene. Item 27 is marked other than "nature!; or items 23a or 28e-f show other treumatic avent, ITE Nacidal Examinations.		Ian Go		n/Son	20b. P	208 lace of Dispo	B Gard	en Ric	dge Roa	id, Ca	tonsvil	le MD 21228 Town, State
			XXCremation	3 Removal from	State C	emetery, crei	natory or otner pia	ice)			urel, Ma	
	oi	21. Signature of 5			/ Delle		ashington . Name and Addr			-		
parmit. Departi		1 ////	line	CX	al	7 155	55 Twi	n Kno				mes, Inc. , MD 21045
1100		23a. Part1. Enter	the disease, or	complications that conly one cause on e	aused the dea							Approximate Interval Between
Physiciar	,	Immediate Cause disease or conditi	(Final	ARTE	RIUSIA	EROT	IC CAI	PDIOV	ASCULA	-Di	sease	Onset and Death
/Medica Examine	_	resulting in death)		Due to	or as a consequ		- 011	1				1
LAGIIIIIC		Sequentially list of	onditions,	b. Due to	or as a consequ	uence off:						
uted I Insit	Examiner	Sequentially list of if any, leading to in cause. Enter Und Cause (Disease o	erlying r injury		,							
be executed sician and burial-transit		that initiated event resulting in death)	Last	C. Due to	or as a consequ	uence of):						
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that the death certifica ed by the attending ph	Med	IF FEMALE:		20.11								
death cer death cer e attendir id for use	Physician/M	23b. Was deceded in the past 12		1 ☐ Live b	come of pregna irth 2 Petal ant at time of de	Ideath 3	Ectopic pregnand Other (specify)	у			23d. Date of del Month	ivery Day Year
the de	ysic	1 ☐ Yes 2 9 ☐ Unknow		9□ Unkno		eaut 3	Citiel (specify)					
	by Pf	Part II. Other sign	ificant conditio	ns contributing to de	eath but not resi	ulting in the u	nderlying cause g	ven in Part I.	23e.	Did tobacc	co use contribute to	the cause of death?
requires  been sig										1 Yes	2 □ No 3 □ Pr	obably 4 Unknown
aw aw 2 sl	ompleted								24a.	Was an autopsy	24b. Were au	itopsy findings available completion of cause of
_ ⊢ ate	Com								1 🗆	performed Yes 2 🗹	death?	
OT VICAL Physician: The this certificate ral director, pag	Be (	25. Was case refe examiner?	rred to medical	Manager					of Death (Check	only one)		
S S	2	1 ☐ Yes 2 ☐ 27. Manner of Dea		Hospital: 1 🔲	npatient 2  of Injury	ER/Outpatier 28b. Time of	IL SELDON	Acres de la constante de la co			6 ☐ Other (Specially occurred	cify)
ding h. After fune	tion	1 Natural 2 Accident	5 Pending	(Mon	th, Day Year)	Injury	Wo	ork? ]Yes 2 □ N		CHEC HOW II	njury occurred	
INISION I or Attending after death. Director: After	ifica	3 🗍 Suicide 4 🗀 Homicide	6 Could n	ot be 28e. Place	of Injury - At ho	me, farm, str	eet, factory, office				and Number or Ru	ıral Route Number,
	Certification;	4   Hottlicide		bullai	ng, etc." <i>(Specit</i> )	<i>(</i> )			City	or Town, Si	iaie)	
Hospitel 24 hours a 6 Funerel [ 16tely filled		29a. Certifier (Check only	1 Certifying	g Physicien: To the Exeminer: On the b	best of my kno asis of examina	wledge, deat	n occurred at the t	ime, date and opinion, death	place, and due to occurred at the	to the cause time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within 2 To the R	Medical	one) 29b. Signature and	d title of certifier		ner stated.		29c Licen	se number		29d	Date signed (Monti	h Day Year)
7 <u>¥</u> 7 8		1	+ > 11	+	7		70 0	a. 1 =		,	-	
1 1		30. Name and add	ress of person	who completed caus	e of death (Item	1 23a) (Type	Print)	749		DE	,	24 D21043
V		BURT	F. MI	BRONIN	1D 2	80 21	MONTELA	IR DR	ELLIC	0TT	CITY M	D21043
	tate	31. Date filed (Mo	DECYPAR	200 A 32. P	egistrar's Signa	ture	B				1/	
Regis	strar				" and a second	13	Space	May 1				

State of Maryland / Department of Health and Mental Hygien 38454 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DEC. 1, 2004 **Physician** Gail Groom 2:07p м Robert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F Months Days Hours Yrs. 56 Director 361-38-2142 6/11/1948 Illinois Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d, Inside City Limits itam 27 ia markad othar than "natural", or Itama 23a or 28a-f show othar traumatic evant. If a Modical Expedition is the notified at Silver Spring 1 □Yes 2 No MD Director Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA Unit 3 3859 Bel Pre Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. parmit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itan any injury or other traumatic event. The Modical Exerticel Once. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 21X No Specify. ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Flower Shop Florist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Hurley Groom Joyce Marie Day ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 19a. Informant's Name/Relationship (Type, Print) Joyce Groom/Mother 288 South Madison St. Pittsfield, Illinois 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/03/04 Beltsville, Md. Chesapeake Crem. 5 Other (Specify) <sup>¹</sup> 4 □ Donation 21. Signature A Faneral Service License e 22 Name and Address of Facility PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician disease or condition resulting in death) Acute Respiratory Distress Syndrome /Medical Due to (or as a consequence of): Examiner Anoxic Encephalopathy Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events Dualto (or sela noneaquanta of): Examiner burial-transit Pneumonia 15 days resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician certificate be Physiclan/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) P.0. the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Alcohal withdrawal Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2X No 1 ☐ Yes Phyaician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: P 1 Yes 2 XNo 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔽 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Hospital or Attending PI 24 hours after death.
Funaral Director: After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D60826 shama 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spring, Md 20910 Kshama Garg M, .D. 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 38455 1- State Registrar AMEND ITEM #8 PER FH G838 TIFE PLAY TO DE 21/19 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 12 Year **Physician** Clarence 100-ton Levo 09:50PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VAMEDICAL CENTER BALTINURE BRECC 8. Date of Birth 9-26-1 9 Purplace (State or Foreign Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Funeral Days Hours 10 M 2 F -01-9813 Yrs. Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director AUTHORE BALTIMOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4102 e or items 23e tololo 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other then any injury or other treumatic..... Elementary/Secondary (0-12) College (1-4or 5+) dor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William HOLTON Manie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOLTOU lor AU 4102 101 DACTIONOGE 20a. Method of Disposition

1 A Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 12-10-0e TTIMELE, MO 21234 - 880 HARFORD PD. 21. Signatur of Funeral Service Lice 23a. Part1. Enter the disease, or complic tion to caused the shock, or heart failure. List only one causes each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Carrin steader /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4□Pregnant at time of death 5 Other (specify) the ( 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Alzheimer 24a. Was an autopsy performed?
Yes 21 No 1 Tyes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 PNo 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 1047804 12/01/2004 30. Nameland address of person who completed cause of death (Item 23a) (Type, Print) A. MROWIE 3900 lock Roven BLVd. 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 0 6 2004 Registrar

			For State Registrar	State of Marylar	nd / Depa		lealth and M	lental Hy	giene (	) L	384	56
	Physicia	an	1. Decedent's Name (First, Middle, Last)	A .	. 1		Death	2. Date of Dea	Reg. No. ath Day	Year	3. Time of	
	/Medic	al	4a. Facility Name (If not institution, give s	RAINE street and number)	HAR		or Location of Death	- 11	27 4c. County	04 of Death	5.11	AM
	LAGIIIII	e.	GOOD SAMARITAN	HOSPITAL		BALTI						
	Funeral Director		5. Social Security Number 6. Sex	1/	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	1934	9. Births	Place (State or	NO NO
	nyland how		Usual Residence of Decedent  10a. State 10b. County	10c. (i	ty, Town or Lo						10d. Inside Cit	-
	the Ma 28e-1 s	ector	MD  10e. Street and Numbers	$\mathcal{D}$	ACII	MORE 101, Zip Code			10g. Citizen of \	What Cou	1 Yes	2 🗌 No
	23a or	al Dir	1019 KEYER	DY ROAD		101. 219 0000	21212			.5./	/1	
936	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show deal Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1		Was Decedent of bill Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Rac Blac Specify	ck, White,	cen Indian, etc. ACK	
2-0	72	eted	15. Decedent's Edu (Specify only highest grade	cation completed)	(Give	dent's Usual Occup	during most of work.	ing	16b. Kind of B	usiness/In	dustry	
21215-0036	d wit	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	iiie.	DO NOT use retire CLERK	a) '		GOVE	RNM	ENT	
Maryland 2	ould be filed Mental Hygi arked other atic event, II	To Be C	17. Father's Name (First, Middle, Last)  JAMES  J	ENKINS		•	18. Mother's Name	/	Maiden Suman	ne) >		
Mar	sh, and le m		19a. Informant's Name/Relationship (Ty,	DO. Pring) IS HUSBAND	19b. Maili	ng Avgress (Street	and Number or Rura  N (VAD)	hATI	or, City or Town,	State, Zip	Code)	
ore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b. i	Place of Dispo cemetery, crea	osition (Name of matory or other pla		Date	20c. Location -			2410
altimore,			* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	WV	OD LAW	N CEME 1 2. Name and Addre	EXY 11.4 ess of Facility VAL	- /	GRE EN			
Ä	permit. Departr Import any Inj		> Vaughs	Green	4	905 YOK	K KOAD	BAU	MORE		212	12
	Physician /Medical		23a. Part1. Enter the disease, or cimpli shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	PULMONARY	DE DE		ng, such as cardiac (	or respiratory ar	rest,		Approximate Interval Betw Onset and D	veen
8	Examiner			Due to (or as a consect AUTE ON		NIC RE	NAL FAIL	URE				
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec								
oʻ	be executed sicien and burial-transit		that initiated events cresulting in death) Last	Due to (or as a consec	quence of);							
68760,	₩ × ₩	dical		1								
Вох	The law requires that the death certificat to has been signed by the attending phyoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{N} \text{No} \) 9 \( \text{Unknown} \)	3c. If yes, outcome of pregn 1 Live birth 2 Fete 4 Pregnant at time of c	aldeath 3	Ectopic pregnanc Other (specify)	у			te of delive		'ear
, P.O.	s that the de	by Phy	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use cont	ribute to t	he cause of de	eath?
ords	w requires been sign should be	ted b		ERY DISEASE				101	res 2 No	3 Prob	oably 4 □U	nknown
Vital Records,	The law cate has b page 2 sh	Completed	SLE VASCU	LITIS					rmed?	prior to co death?	ppsy findings a impletion of ca	
ital		Be Co	25. Was case referred to medical examiner?				26. Place of Deatl	(Check only o	ne)	1 🗌 Yes		
of	Phys r this ral dir	္	1 ☐ Yes 2 🕱 No	lospital: 1 Inpatient 2 2	ER/Outpatier		ner: 4 □ Nursing Ho		ience 6 Doth		(y)	
ion	Attending F death. ctor: After y the funer	ation	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	Wo	rk?  Yes 2□No					
Division	l or Atta after de Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str fy)	reet, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rura	al Route Numb	oer,
_	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Physical Check only 2 Medicel Exemical Medicel Exemical Physical Control on the Con	sicien: To the best of my kniner: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and place, opinion, death occurr	and due to the o	cause(s) and madate and place,	inner as s and due to	stated. o the cause(s)	
	To the within 2.	Me	29b. Signature and title of certifier	10		29c. Licens			29d. Date signe		Day, Year)	
•	5		30. Name and address of person who co	moleted cause of death /Ita	m 23a) (Tuno	Print)	000		11 27 /			
			@ IZUKANJI SIK	AZWE , 5601	WILL A	PAUEN B	LUD, BALT	IMORE	21239	. M	0	
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 6 2	32. Registrar's Sign.	ature	hon	Kal					

		1 - For State Registrar 1. Decedent's Name (#			Се	rtificate of	Death	2. Date of Dea		3. Time of Death
Physici /Medi		Mary Virg	ginia Ha	11				Nov. 2	8th <sup>a</sup> ,2004	4:47рм
Examir		4e. Facility Name (If no					or Location of Deat	h	4c. County of	Deeth
, L		Prince Geo	har 6 S	7 Ace	(In yrs. last birthday	Chever I	J If Under 24 Hrs.	8. Date of Birt	PG	9. Birtholeca (State or Foreign
Funeral Director		577-50-6558 Usual Residence of De	3 1	M ZHF	68 Yrs.	Months Days	Hours Min.	(Month, Da	7, Yeer) 10,1936	9. Birthplece (State or Foreign Country) Murfreesboro, N
how		10a. State	0b. County		10c. City, Town or L					10d. Inside City Limits
Hilling	Director	MD	PG		Capito1					1X Yes 2 No
pe n	Dire	10e. Street and Number		<b>#T</b> O		10f. Zip Code			10g. Citizen of Wh	nat Country?
ns 23e	eral	6512 Ronal	а коаа	# I Z 12. Was Decedent Ev	rer in U.S. 13	20743 Was Decedent of H		Specify Yes or No	US - 14. Race	- American Indian,
Department of Health and Mental Hygiene. Important: If items 23a or 28a-f ahow important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avant, its Medical Examinar must be notified at 2006s.	by Funeral	1 ☐ Never Married 3 ☑ Widowed 4 [		Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:		If Yes, specify Cub  1 ☐ Yes 2 No	an, Mexican, Puèri Specify:	to Rican, etc.)	Bleck,	White, etc. Black
netur ical	ted		5. Decedent's Ed only highest gra		16a. Dec	edent's Usual Occup e kind of work done	pation during most of wo	rkina	16b. Kind of Busi	iness/Industry
nen Tr	Completed	Elementary/Second		College (1-4or 5+	life.	DO NOT use retire abled	d)	3	None	
lygier ther th nt, thu	S	12th 17. Father's Name (Fit	rst Middle (ast)				18. Mother's Nar	me (First, Middle,	Maiden Sumame,	)
ed of	Be c	Leander Jo					Odell T		,	
mark mark	P	19a. Informant's Nam		Type, Print)	19b. Mai	ling Address (Street			er, City or Town, S	tate, Zip Code)
27 la		Renee V. S	Scott (d	aughter)	6512	Ronald R	oad #T2 (	Capital	Heights,	MD 20743
ent of He nt: If item ry or othe		20a. Method of Dispos 1 Burial 2 0 4 Donation 5	Cremation 3 🗆	Removal from State		osition (Name of ematory or other place) od Cemete	l)ec	4,2004	20c. Location - C	on DC
Departm Importa any inju once.		21. Signature of Fune	rat Service Licen	see	9/16	Austin Ro	yster Fu	neral Ho	me	3-7-3
U E Ü		a. Part1 _mer the	disease, or com	plications that caused tone cause on each line	he death. Do not er	3821 14th nter the mode of dyi	ng, such as cardia	NW Wash1 c or respiratory ai	ngton, DC rrest,	Approximate Interval Between
sician and burial-transit	lical Examiner	disease or condition resulting in d ath)  Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or injust initiated events resulting in death) Las		b. End Stage Due to (or as a Atherosc	consequence of):  Dilated consequence of):  lerotic H consequence of):	Cardiomy Ventricul	opathy w ar Dysfui	ith Seve		
ed by the attending phys detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ N 9 □ Unknown	onths?	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetel death 3	☐Ectopic pregnanc	у		23d. Date Mont	of delivery h Day Year
D @		Part II. Other significa	ant conditions o	ontributing to death but	not resulting in the	underlying cause gr	ven in Part I.	23e. Did t	obacco use contrib	oute to the cause of death?
peu e de	ed b	Incarcera	ated Abd	<u>ominal Her</u>	nia s/p E	xplorator	y Laparo	tony 10	Yes 2□No 3	Probably 4 X Unknown
nn signed uld be dei	iet							24a. Was autop perfo 1 - Yes	osy pri ormed? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
has been sign je 2 should be	omp						26. Place of De	ath (Check only o		
ate has been sign page 2 should be	3e Completed by	25. Was case referred	d to medical		_	_ 0:	her: 4 Nursing H	Home 5 ☐ Resid	dence 6 Other	(Specify)
is certificate has been sign director, page 2 should be	o Be	25. Was case referred examiner?			t 2 ER/Outpation	BILL 3D DOX				
is certificate has been sign director, page 2 should be	To Be	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 2 Accident	o 5 □ Pending investigation	28a. Date of Injury (Month, Day	28b. Time	of 28c. Inju		28d. Describe I		
is certificate has been sign director, page 2 should be	To Be	examiner? 1 Yes 2 No. 27. Manner of Death 1 Natural	o 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	of 28c. Inju	ry at		Street and Number	r or Rural Route Number,
4 hours after death. Funeral Diractor: After this certificate has been sign ely filled in by the funeral director. page 2 should be	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day	Year) 28b. Time Injury  y - Al home, farm, s (Specify)  my knowledge, deaxamination and/or	of 28c. Inju Wo M 1  street, factory, office	ry at rk? ] Yes 2 □ No ime, date and plac	28f. Location (Scity or Townson, and due to the	Street and Number	r or Rural Route Number,
for death. Director: After this certificate has been sign in by the funeral director, page 2 should be	To Be	examiner?  1 Yes 2\( \) No  27. Manner of Death  1\( \) Natural  2 \( \) Accident  3 \( \) Suicide  4 \( \) Homicide  29a. Certifier  (Check only 2	5 Pending investigation 6 Could not be determined	28a. Date of Injung (Month, Day)  28e. Place of Injung building, etc.  299. Place of Injung building, etc.  299. Place of Injung building, etc.	Year) 28b. Time Injury  y - Al home, farm, s (Specify)  my knowledge, deaxamination and/or	of 28c. Inju Wo M 1  street, factory, office	ry at rk? Yes 2 \( \sum \text{No} \) when the date and place opinion, death occi-	28f. Location (City or Ton	Street and Number wn, State) cause(s) and mani date and place, an	r or Rural Route Number,
4 hours after death. Funeral Diractor: After this certificate has been sign ely filled in by the funeral director. page 2 should be	edicai Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Notural  2 Accident  3 Suicide  4 Homicide  29a. Certifier  (Check only one)	5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	Year) 28b. Time Injury  y - Al home, farm, s (Specify)  my knowledge, deaxamination and/or	of 28c. Inju Wo M 1 Catreet, factory, office ath occurred at the tinvestigation, in my	ry at rk? Yes 2 \( \sum \text{No} \) when the date and place opinion, death occi-	28f. Location (City or Ton	Street and Number wn, State) cause(s) and mand date and place, and	ner as stated. ad due to the cause(s)  (Month, Dey, Year)

				1- For State of Maryland / Department of Health and Certificate of Death		liene 0 0 4	38458
		Physici		1. Decedent's Name (First, Middle, Last)  Anne L. Haskins	2. Date of Dea Month November	Day Year	3. Time of Death 9:50 AM M
	7	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Joseph Richey Hospice  4b. City, Town, or Location of Deat Baltimore		4c. County of Death	1
	l	Funeral Director		5. Social Security Number 219-20-5665 6. Sex 1 Months 2 F 82 82 1 Months 2 Months 1	8. Date of Birth (Month, Day) Mar 30,	, Year) Cour	lace (State or Foreign stry) 1 and
		Aaryland show	o.	Usual Residence of Decedent		1	Od. Inside City Limits
		death with the Maryland ms 23a or 28a-f show friust be rolliked at	Direct	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cour	
			Funeral Director	11. Marital Status  1 Never Married 2 Married	Specify Yes or No- to Rican, etc.)	USA 14. Race - Americ Black, White,	an Indian,
	-0036	72 hours after natural', or ite	ρ	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify:		Specify: 1	lack
	21215	within 72 iene. 'then "na ine Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  10  (Give kind of work done during most of wo life. DO NOT use retired)  silk presser	rking	you. Itilia of Basillosaille	unk unk
	land 2	ld be filed ental Hyg ked other ic avent,	To Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	me (First, Middle, I	Maiden Sumame)	
	Mary	d 2 shou th and M 7 ie mar traumat	-	19a. Informant's Name/Relationship (Type, Print)  Joseph Richey Hospice  19b. Mailing Address (Street and Number or Richest Research Print)  838 Eutaw Street Balt			Code)
50 AM	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avent, Ite M. ODG.		Joseph Richey Hospice  20a. Method of Disposition 1		$rac{D}{21201}$ 20c. Location - City or To	wn, State
150	Balt	permit. Departr Imports any inje		21. Signature of Funeral Service Licensee  Romald S Wald Darkstor  22. Name and Address of Facility State Anatomy Boar Baltimore, MD 2120		Baltimore S	treet
11/25/64	8760,	Certificate be executed with the principle of the princip	dical Examiner	23a. Patr1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	io Võizella	Br HEEL	Approximate Interval Between Onset and Death
XS	.O. Box 6	certifi Iding	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Temperature of death 5 Other (specify)		23d. Date of delive Month	ory Day Year
Hask	Vital Records, P.	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Completed by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Demonstrated by Annual Contributing to death but not resulting in the underlying cause given in Part I.		prior to cor death?	ably 4nown  Dosy findings available inpletion of cause of
nne	of	ng Physician: Iter this certifica ineral director, i	To Be	examiner / 1	ath <i>(Check only on</i> dome 5 Reside	V	Digila
4	Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could be deterned 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Towr		
		the Hosp in 24 hou the Funer	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	urred at the time, da	ate and place, and due to	the cause(s)
•		with To	M	29b. Signature and title of certifier  29c. License number  29c. License number	21	9d. Date syned (Month,	Pay, Year)
		Sta Registr	. 4	30. Na/he and address of person who completed cause of death (Item 23a) (Type Print)  31. Date filed Worth Day, Year)  32/Registrar's Signature	Both,	11/2/	2/8

State of Maryland / Department of Health and Mental Hygien 🗲 🕦 🗓 38459 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 1:40 AM 2004 HJUH JOHNSON THOMAS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COAD Air HARFORE NOHT PIES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 13€ M 2□ F Yrs 316-52-6144 Director 1ARY Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show is marked other than "natural", or items 23a or 28e-f shov sumatic event, the Madical Exeminar must be notified at 1 ☐ Yes 250 No BELAIR MARYLAD HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? KOAD 2319 THOMAS 81012 .14 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 🚜 Marned 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 28 No þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HainTinb CONTRACTOR 137RS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HJUH 2 3020HOC 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21015 19a. Informant's Name/Relationship (Type, Print) nt of Health a : If item 27 is 2319 THOMAS 16001 KOAO BREADA SHERA JOHAGO 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ò permit. Pagi Department Importent: If any injury or \*4 □ Donation 5 □ Other (Specify) 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HARL 3 12 WHORT DRIVE FORESTHILL I HARYLAND 21050 100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one rause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Stage **Physician** EUN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed 1040 Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ZÎNo 3 Probably 4 □Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has DUSTON 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA SIL 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: / d in by the f 3 🖺 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completery filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as status. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signatuse and title of certifier 29d. Date signed (Month, Day, Year) 02 ame and address of page on the completed suse of death (Item 23 / N ype, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 6 2004

Johnson

04-7503 B.K.S UNKNOWN 04-379

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygierre 0 0 4

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DONI	ГА М. ЈОНТ	NSON		Cen	tificate of	f Death		Reg. No.	14 0	00400
	Di	1. Decedent's Neme (First, Middle, La	est)				2. Dete of De Month	eath Day	Year	3. Time of Death
	Physician /Medical	Donta	Μ.	John	son		NOV.	22, 20		0734 AM
	Examiner	4a Facility Name (If not institution, given UNIVERSITY HOS	re street end number) PITAL			4b. City, Town, or L BALTIMO			of Death NA	
	Funeral Director	212-96-8184	Sex 7. Age (In yrs. 26	last birthday) Yrs.	If Under 1 Year Months Day		8. Date of Bir (Month, Da 7-11	rth ay, Year) 1–78	9. Birthplac Country	ce (State or Foreign y) Md.
	and w.	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loc	ation				10d	I. Inside City Limits
	Menyl Fresh tred	Md. NA	F	Baltimo	re					1 X Yes 2 □ No
	or 28s	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country	17
	23a c	2805 Winwood Ct	•		2122			USA		
Maryland 21215-0020	hours effer death with the Meryland tural; or items 23a or 28a-f show al Examiner must be notified at ed by Funeral Director		12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 [YNo If Yes, Give Year or Dates:		/as Decedent of Yes, specify Cu ☐ Yes 2 🗓 No	f Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	pecify Yes or No Rican, etc.)	5- 14. Ra Bla Specif	ce - American ck, White, etc	
5-0	n 72 hours "natural", nairal Eur	15. Decedent's E (Specify only highest gra	ducation ade completed)	16e. Decede	ent's Usuel Occi	upation e during most of work red)	king	16b. Kind of B	usiness/Indus	stry
121		Elementary/Secondary (0-12)	College (1-4or 5+)		o not use retir ver Worl			NA		
9		10th grade  17. Father's Name (First, Middle, Last	)			18. Mother's Nam	ne (First, Middle		ne)	
lan	nd 2 should be fill the and Mental H 27 is marked out of traumatic ever	Windell	Johnsor	ı, Sr.		Eller	1	p	errin	
ary	shou and M a mer umet	19a. Informant's Name/Relationship			Address (Stree	et and Number or Rui				ode)
	es 1 end 2 of Heelth a item 27 is r other tra	Ella Perrin	Mother	2805	Winwoo	d Ct., Bal				
Baltimore,	permit. Pages 1 en Department of Heeli Important: If Item 2' any Injury or other DRCB.	20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Special Control Co	Removal from State	emetery, crem	ition (Name of atory or other pi		Date 12-4-04	20c. Location  Dunda	,	
Salt	permit. Departin Importa any Inji	21. Signature of Funeral Service Lice			Name and Add			nore, Md	3000	
щ	20 E 9 9	Glady	w one	Ma	arch F.	H. East		. North		
	hysician and Street be executed by the bural-transit sthe bural-transit sedical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Just but Due to (o	V sur di vir as a consequir as a consequi	ience of):	led			O	pproximate tierval Between Inset and Death
Box 68760,	E 00 5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d	r as a consequ						
P.O.	the de sched	Part II. Other significant conditions	ontributing to death but not resi	ulting in the un-	derlying cause g	given in Part I.		tobacco uae co Yes 2□ No		ne cause of death?
	es thet igned be detailed by PI							163 20110		77
Division of Vital Records,	200						24a. Was perio	an autopsy omed?	availa	autopsy findings able prior to pletion of cause ath?
Ä	The law ste hes page 2						1X	Vae 2□No	1)XY	res 2□ No
/ita	certificete rector pag	25. Was case referred to medical examiner?				26. Place of Deal	th (Check only	one)		
<b>f</b>	Physic this c ral dire	1 No 27. Manner of Death	Hospital: 1 Inpatient 200	ER/Outpatient 28b. Time of	3LI DOA			dence 6 Oth		
5	ding F. h. After funer	1 ☐ Natural 5 ☐ Pending	(Month, Day Year)	Injury 50/	28c. lnj W 1 [	ork? □ Yes 2 ¥ No	Subscribe	+56+	-	
Divisi	To the Hospital or Attending Physician: The I within 24 hours efter death.  To the Funeral Director: After this certificate he completely filled in by the funeral director. page Medical Certification: To Be Com	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury - At he building, etc. (Specify	ome, farm, stre		1	28f. Location (City or To	(Street and Numi wn, State) 234	per or Rural R	PANEULE
	he Hospita in 24 hours he Funeral pletely fille edical C	29a. Certifier 1 CertifyIng Ph (Check only one) 1 Medical Exer	hysician: To the best of my knowniner: On the basis of examinational and manner stated.	wledge, death	occurred et the estigation, in my	time, date and place, opinion, death occur	and due to the red et the time,	ceuse(s) and m date and place,	anner as stete and due to th	ed. e cause(s)
-	To the vithin comp	29b. Signature and title of certifier	1		29c. Licer	nse number		29d. Date signe	d (Month, Da	y, Year)
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V	State	31. Date filed (Month, Day, Year)	32. Registrar's Signa		· ·		-,			

			1- State C	of Maryland / Dep		Health and Mental Hy  Death	•	38461
	Physici	an	Decedent's Name (First, Middle, Last)	cal Fola	n fon	2. Date of D Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and nu Mercy Hospital		4b. City, Town, o	No Vemor Location of Death timore	4c. County of Dea	
	Funeral Director		5. Social Security Number 218–36–2753 6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of B (Month, D) 8-3		thplace (State or Foreign puntry)  Md.
	inyland show	_	10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
	the Ma	Director	Md. NA	Balti	10f. Zip Code		10g. Citizen of What Co	Yes 2 No
	h with 23a or st be	ai Dir	4111 St. George's Ave.		2121	8	USA	Santy.
980	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural, or itema 23a or 28a-f show event, I'le Mydical Exartimer rust be praffied at	by Funeral	11. Marital Status 12. Was Dec Armed Fo	2 X No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	tispanic Origin? (Specify Yes or N an, Mexican, Puerto Rican, etc.) Specify:		
15-0	n 72 hc "natur	letec	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working	16b. Kind of Business	/Industry
212	d within giene. er than	Completed	Elementary/Secondary (0-12) College (	1-4or 5+)		Maintenance	State of M	ld.
Maryland 21215-0036	2 should be filed within and Mental Hygiene. is marked other than aumatic event, II:e M	Be	17. Father's Name (First, Middle, Last)	Johnson		18. Mother's Name (First, Middle Ollie		hnson
aryla	ges 1 and 2 should it of Health and Men if item 27 is marke or other traumatic	J.	Edward L.  19a. Informant's Name/Relationship (Type, Print)		ng Address (Street	and Number or Rural Route Numb		
	s 1 and 2 f Health a item 27 is			ster 113		alou Street, Bal		
Baltimore,	permit. Pages 1 Department of H Important: If ites any injury or ott		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from  '4 ☐ Donation 5 ☐ Other (Specify)	cometany cra	matory`or other plac	12-3-04	20c. Location - City or Randallstow	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee		Name and Addre	Da.	ltimore, Md. E. North Ave	21202
	Physician		23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on of Immediate Cause (Final disease or condition a.	each line.	ter the mode of dyir	ng, such as cardiac or respiratory a		Approximate Interval Between Inset and Death INK 5
	/Medical Examiner			(or as a consequence of):				
	ed sit	ulner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of):				
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Division	or Attending siter death. Director: After in by the fune	Certification;	2 Accident investigation	e of Injury - At home, farm, str ing, etc. (Specify)			Street and Number or Ru wn, State)	ral Route Number,
	To the Hospitel or Attenc within 24 hours efter death To the Funeral Director: completaly filled in by the	Medical Ce	(Check only 2 Medical Examiner: On the b	e best of my knowledge, deatl asis of examination and/or in ner stated.	h occurred at the tin vestigation, in my o	ne, date and place, and due to the pinion, death occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
)	To th within To th compl	Me	29b. Signature and title of certifier	D	29c. Licens		29d. Date signed (Month	
1			Newsiac Val I wild	se of death (Item 23a) (Type,	Paul P	lace Backon	November vê MD 2	21202
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				State of Maryla					_	
			1 - For State Registrar	Otato or maryta		rtificate of		_	Reg. No.	14 38462
			1. Decedent's Name (First, Middle, La	st)				2. Date of De	path Day Yee	3. Time of Death
	Physici Medic!		LOIS P.	Jones				Dec.		1 27 7 29 44
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of Dea	th	4c. County of D	11.
		ш	Northwest	Hospital	and hinth day	If Under 1 Year	CCIIST	NVO		Itimore
	Funeral Director		5. Social Security Number 6. S	□M 2DXF	rs. last birthday Yrs.	Months Days	Hours Min	. (Month, Da	16,1933	Birthplace (State or Foreign Country)  NC
T			213-32-4120 Usual Residence of Decedent	71				Augusi	10,1933	NO
000	how	L	10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
M o	89-68	Director	MD BALTI	MORE	WOODLA					1X Yes 2 □ No
books with the Manual	ror 2 Terra	Fe	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
400	18 236	era	6713 KINCHELOE AV	ENUE  12. Was Decedent Ever in	1115 13		. 207 Hispanic Origin? (1	Specify Yes or No	USA	merican Indian,
		Funeral	1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 🕅 No	10.5.	Was Decedent of If Yes, specify Cub		rto Rican, etc.)	Black, W	
0000	ous aret dean win tre maryra ral', or Items 23a or 28e-f show Ezantinar must be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2🌠 No	Specify:		Specify:	BLACK
3 0	netu	Completed	15. Decedent's E	ducation ade completed)	(Give	edent's Usual Occu	during most of we	orking	16b. Kind of Busine	ss/Industry
7	han Me	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	rd)			
7 7	Hygie ther t		17. Father's Name (First, Middle, Last,	5+	TE.	ACHER	18. Mother's Na	me (First, Middle	BALTO . C. Maiden Sumame)	ITY SCHOOLS
מוב	sed o	o Be	GOLD POTEAT					WILLIAM		
aryia	mari mari	J.	19a. Informant's Name/Relationship (	Type, Print)	19b. Mail	ing Address (Stree			er, City or Town, State	e, Zip Code)
ž į	alth a 27 le		ANDREA ROGERS/DAU	GHTER	32 1	WYNDMOOR	PL. APT.	D BALTI	MORE, MARY	YLAND 21207
e,	of Hear fitem rothe		20a. Method of Disposition		b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ice)	Date	20c. Location - City	or Town, State
OE S	ment of tent: If it tent: or o	11 8	1√28urial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specif	y) CI	ROWNSVI	LLE VET.	CEM. 12-	9-2004	CROWNSVII	LLE, MARYLAND
Dalt	Departi Import any inj once.		21. Signature of Funeral Service Licer	isee — T						ONS F.H., INC.
	70 E 8 9		James	1. Mor	_ , ,	1701-31 I		<del></del>		RYLAND 21217
			23a. Part1/Enter the disease, or com shock, or heart failure. List only	one cause on each line.	eath. Do not er	iter the mode of dy	ng, such as cardia	ic or respiratory a	rrest,	Approximate Interval Between Onset and Death
and a	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a agric	ua	spry	iation			-
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- 9	physic the b	dicai		_d. /	ucos,					
XO	attending physical of for use as the b	/Me	IF FEMALE:	23c. If yes, outcome of pre-	gnancy				23d. Date of	delivery
n ş	ne atter	clar	23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of		□Ectopic pregnand □ Other (specify) _	У		Month	Day Year
j	by the	Physician/Med	9 Unknown	9□ Unknown						
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cords	been sig	ted	acure re	nal fai	un	e, ai	uar	1 🗆 '	Yes 2 No 3 1€	Probably 4 Unknown
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0	ning rilystolan. h. After this certific funeral director,	To To	1 ☐ Yes 2 ☑ No 27. Many of Death	28a. Date of Injury (Month, Day Year	28b. Time	of 28c. Inju	ry at		dence 6 Other (S)	pecify)
0	ith. r: Afte e func	atior	1 Natural 5 Pending 2 Accident Investigatio		) Injury		rk? ]Yes 2 □ No			
DIVISION	er death rector: by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		it home, farm, si	treet, factory, office		28f. Location (: City or To	Street and Number or wn. State)	Rural Route Number,
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	yo the hospital of Attendal within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	ledical	29a. Certifier 1 Certifying Pt (Check only 2 Medicel Examone)	nysicien: To the best of my l miner: On the basis of exam	knowledge, dea nination and/or in	th occurred at the tancestigation, in my	ime, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and manner date and place, and o	as stated. lue to the cause(s)
4	within 2 To the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed (Mo	onth, Day, Year)
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	11		89. Name and address of person who	completed cause of death (	Item 23a) (Type	Print)	1)/)(	^	UK.	7 200/
	/		Charles mo	are II	nor	thives	T Ha	Sp. Ka	rdales to	m md:
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ennis /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death imore Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Funeral 9. Birthplace (State or Foreign Country) 218-46-846 Director R Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location Item 27 is marked other then "natural", or Items 23s or 28s-1 show other traumatic event, the Wedical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other then "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumam EENE DURNEY Informant's Nam Relationship (Typg, Print) 19b. Mailing Address (Street and Number or Rural Route Number ages 1 and 2 so to of Health an tf Item 27 is s 20b. Place of Disposition (Name of 20a. Method of Disposition Date Pages nent of h 20c. Locatio Burial 2 Cremation 3 Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 21. Sign we of Funeral Service-Licensee 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of physician and the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery ō in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 2□ No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: Medical Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending s after de... •• I Director: Att 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours e 1 Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person State strar's Signature Registrar DEC 0 6

			1 - For State of Maryland / Dep. General State of Maryland / Dep. Ce	artment of Health and Me rtificate of Death	ental Hygien Reg. N	2004 3846	l,			
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Robert Kurrle	2	2. Date of Death Month Da November					
	Examin		4a. Facility Name (If not institution, give street and number) 2435 Cullison Drive	4b. City, Town, or Location of Death Manchester	44	c. County of Death  Carroll				
Č.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 12 of 57 Yrs.	Months Days Hours Min.	3. Date of Birth (Month, Day, Year Dec 2, 19		ign			
	iryland thow		Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Li	ocation hester		10d. Inside City Lim 1 ☐ Yes 2X 1				
	be filed within 72 hours after death with the Maryland ital Hygiene.  do other than "neturel", or Items 23a or 28e-f show event, I're Medical Examinan must be notified at	Funeral Director	10e. Street and Number	10f. Zip Code	10g. C	j. Citizen of What Country?				
	23a o	ai D	2435 Cullison Drive	21102		USA				
	Items !	uner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 ▼ Yes 2 □ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.				
3036	rel', or	þ	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates: 167-73	1 ☐ Yes 2 No Specify:		Specify: white				
21215-0036	nin 72 h  in "netu Wedica	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b. I	Kind of Business/Industry				
2	d with giene er the	mo)	12	supervisor		construction				
and	d be file ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last) William Bruce Kurrle	18. Mother's Name (		n Sumame)				
Ž	should nd Me mark mark	ို		ing Address (Street and Number or Rural		or Town, State, Zip Code)				
Š	alth ar		Elizabeth Kurrle/daughter 404	High Street New Win	ndsor, MD	21776				
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at ance.		1 □ Burial 2 □ Cremation 3 □ Hemoval from State  1 □ Donation 5 □ Other (Specify) in state	osition (Name of Da matory or other place)	te 20c. L	ocation - City or Town, State				
Balt	permit. Depart Import any inj		Renald S. Wage Warrector S	2. Name and Address of Facility tate Anatomy Board altimore, MD 21201	655 W. Ba	ltimore Street				
l,	Pnysician /Medical Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.								
			Immediate Qause (Final disease or condition resulting in death)  a. — A S C V I J  Due to (or as a consequence of):			minutes				
		_	Sequentially list conditions, b. — Buch (conditions)							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or number that initiated events							
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dical Exa	resulting in death) Last  Due to (or as a consequence of):							
9	artificate ing phy e as the	Medi	IF FEMALE:				- 8			
P.O. Box	that the death certific ed by the attending p detached for use as I	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year	,			
	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		tobacco use contribute to the cause of death?  Yes 2 \( \sum \text{No} \) 3 \( \sum \text{Probably} \) 4 \( \frac{1}{2} \sum \text{Unknown} \)				
Vital Records,	2 3 2	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings availal prior to completion of cause of death?  1 □ Yes 2 □ No	ble of			
Vita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (						
of	ding Phys h. After this funeral dir	on: To	27. Manner of Death  Natural 5 Pending  No Prospital: 1 Inpatient 2 ER/Outpatie  28a. Date of Injury (Month, Day Year)  (Month, Day Year)  Natural 5 Pending	of 28c. Injury at Work?	e 5 Residence	6 ☐Other (Specify)  ury occurred				
Division	I or Attendi after death. Director: A I in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 Tes 2 No		ocation (Street and Number or Rural Route Number, City or Town, State)				
Ω	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical Ce	29a. Certifier  (Check only   Certifying Physician: To the best of my knowledge, deal   (Check only   Medical Examiner: On the basis of examination and/or in							
	ro the l	Med	one) and manner stated.  29b. Signature and title of certifien	29c. License number		ate signed (Month, Day, Year)				
)	- > - 0		mobile 18 till 1	P0051924	Nova	ember 29, 2004				
			30. Name and address of person who completed cause of death (Item 23a) (Type, Herbert P. Hern Jerson Tr-M) 2a73 Manch of the	0 1 1	MO 2110	2				
•	Sta Registi		31. Date filed (Month, Day, Year)  DEC 0 6 2004  32. Registrar's Signature	ponels						

			For State	State of M	aryland / Dep	oartment e ertificate	of H	ealth	and M	lental Hy	gien	200	L	38465
			Registrar  1. Decedent's Name (First, Middle, L			runcate	OI L	Jeain		2. Date of De	Reg. No	0.	-	
	Physic		Albert A. Lom							Month	Day Year			3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, g			4b. City, To	own or	Location	of Death	7			04	18 30 1 M
	LAGIII		St. Agnes H	ospital		Balti	Mo		MD		1	. County of t	Jeath	
	Funeral				e (In yrs. last birthda		Year	If Under		8. Date of Bir	th	9.	Birthpl	lace (State or Foreign
	Director		213-07-3334	1 <b>X</b> M 2□F	92 Yrs.	Months [	Days	Hours	Min.	8. Date of Bir (Month, Da March	20°,	1912 I	tal	try)
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation								
	Mary! f sho	ō		timore									10	0d. Inside City Limits 1 ☐ Yes 2 ※ No
	28e	lec.	10e. Street and Number	LIMOTE	Caton	sville 10f. Zip Co	ode				10a Ci	tizen of Wha		
	h with	D	1515 Copeland	Road		1	122	R			Tog. Ci	U.S.		uy?
	deat	ner	11. Marital Status	12. Was Decedent	Ever in U.S. 13				gin? (Spe	ocify Yes or No Rican, etc.)	-	14. Race - /		an Indian.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygisne. Item 27 is marked other than "neturel", or Items 23e or 28e-f show other treumatic event. The Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give	40	If Yes, specify  1 ☐ Yes 2 🛣		n, Mexicar Specify:	i, Puerto	Rican, etc.)		Black, V	Vhite, e	otc.
215-0036	turel al Ex	ed b	3 Widowed 4 Divorced	Year or Dates:	10.5							Specify:		hite
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ğ	e filed I Hyg othe	a)	17. Father's Name (First, Middle, Las	t)	556	ET WOLK		18. Mothe	r's Name	(First, Middle,		el Inc	lust	ry
Maryland	S should be filed within and Mental Hygiene. Is marked other than sumatic event, the M.	To B	Fiore Lombard	li						e Carmo		,		
lary	2 should I and Meni Is marke eumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ing Address (S	treet an			I Route Numbe			е, Zip (	Code)
	1 and 2 Health em 27 I		Victor Lombardi	(Son)						Baltimo				
ore	0 0		20a. Method of Disposition 1   Burial 2 □ Cremation 3 [	Removal from State	20b. Place of Disp cemetery, cre	osition (Name o	of r placel		D	ate		ocation - City		
altimore,	Pag ment ent: ury c		'4 □Donation 5 □ Other (Spec	ify)	Lakeview Park	Memoria	al	_   1	2 <b>-</b> 3-	2004	Syke	sville	. N	faryland
Ba	permit Pages 1 and. Deparment of Health Importent: If item 27 any injury or other tr.		21. Signature of uneral Service Lice	M012	90 4	2. Name and A	uner	of Facility	lome	of Cato				No.
	_		23a. Part1. Enter the disease, or conshock, or heart failure. List only	pplications that caused	the death. Do not an	ter the mode of	f dying,	such as	cardiac o	respiratory ar	rest,	TITE,		Approximate
Ш	Physician		Immediate Cause (Final disease or condition	Acute	Renal 1	mil110								Interval Between Onset and Death
H	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):									odays
٦	Examiner	L.	Sequentially list conditions,	b. Pheum	onia								11	days
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Dirato (or as a	A / / /									2 days
	xecut and II-tran	хап	that initiated events resulting in death) Last	c. Amal 1	consequence of):	n							//	2 days
68760,	ficate be executed physician and is the burial-transit				3377334237733 377.									
687		edical		d									+	
Вох	death certifi e attending p id for use as	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy							23d. Date of	dolinon	
	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at t		⊒Ectopic pregn. ⊒Other (s <i>pecif</i> )					-	Month	,	ay Year
P.0	that the de led by the a detached t	hys	9 Unknown	9□ Unknown										
	res tha signed I I be det	by P	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause	e given	in Part I.		23e. Did to	bacco u	se contribute	to the	cause of death?
ord	w requires been sign should be	ted	Chronic obstruct	GVA PUIN	onary a	15 eas-	1_			1 □ Y	es 2/2	<b>€</b> No 3□	Probab	oly 4 🗆 Unknown
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= H	Th ate pag	Con								autops perform	ned? 2 X No	death	?	oletion of cause of
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				2	6. Place	of Death	(Check only on			-	
of	S S S	2	1 ☐ Yes 2 XNo	Hospital: 1 Inpatien			Other:		sing Hom	e 5 🗆 Reside	ence 6	☐Other (S	oecify)	
uc	ding I	lo	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	,	Injury at Work?			3d. Describe ho	ow injury	occurred		
Division	l or Attending after death. Director: After in by the fune	ficat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b		y - At home, farm, str			s 2□N		26 1				
<u>S</u>	after after Direction by	Certification:	4 Homicide determined	building, etc.	(Specify)	eet, ractory, om	ICO		28	3f. Location (St. City or Town	reet and n, State)	Number or	Rural F	Route Number,
	pspite hours inere		29a. Certifier 1 Certifying Pt	nysician: To the best of	my knowledge, deat	occurred at th	e time.	date and	place, an	nd due to the ca	ausa(s)	and manner	ae etat	ad.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exar	niner: On the basis of a and manner state		vestigation, in m	ny opini	ion, death	occurred	d at the time, da	ate and	place, and d	ue to th	ne cause(s)
	To t with To t	M	29b. Signature and title of certifier			29c. Lic	ense n	umber				signed (Mo		
Ė	1		Thele Pore	MD			P/8	61	8	/	Vone	emper	28	,2004
4	6		30. Name and address of person in Shill Scha MD	completed cause of dea						MA	7 15	000		, 2004
	Sta		31. Date filed (Month-Day Year)	32. Registrar		C 100	471	MOY	e 1	ND:	47	-7		
	Registra	ar	8€€ 0 6 2	1004 Sen	wa &	Lan	200	,						

Albert A. Lombardi

	1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F rtificate of		Mental Hy	/giene (	04	381	+66
Physician	Decedent's Name (First, Middle, Last)					2. Date of D Month	_	Year	3. Time of	
/Medical	Enriqueta B. Lopez-			45 Ot . T		Decemb				Ам
Examiner	Casey House Montgon		ice	Rockvill	r Location of Death e			ty of Death gomery	<b>J</b>	
Funeral	Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi (Month, D			lace (State o	or Foreign
Director	109-32-3300	M 2XF	77 Yrs.	Months Days	Hours Min.	Nov. 1	, 1927	Hond	uras	
land ow	Usual Residence of Decedent  10a. State 10b. County	1	10c. City, Town or Lo	ocation	· · ·			1	Od. Inside C	ity Limits
Mary a-f sh lifted	Maryland Montgome:	ry	Rockville	!					1 ☐ Yes	2 <b>√</b> No
death with the Maryland ims 23s or 28s-f show triust to notified at an eral Director	10e. Street and Number	·································		10f. Zip Code		-	10g. Citizen of	What Coun	itry?	
s 23c	5 Old Club Court			20852			United			
Sufer death with the Mariter death with the Mariter must be notified	11. Marital Status  1 □ Never Married 2X Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N		Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	0- 14. Ra	ace - Americ ack, White,		
036 burs at	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1X Yes 2□ No	Specify: Hondura	ın	Spec	<sub>ify:</sub> Whit	ρ	
21215-00 led within 72 hou ygiene, har than "natura nt, the Medical E	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup	ation during most of work		16b. Kind of I	Business/Inc	dustry	
121 within ene. than	Elementary/Secondary (0-12)	College (1-4or 5-	<b>⊢</b> )	oo not use retired sh Teache	,		Montgo Public			
ind 2 be filed tal Hygin event, II Be Cc	17. Father's Name (First, Middle, Last)		Spailt	sii reaciie	18. Mother's Nam	e (First, Middle	, Maiden Suma	ıme)		
/lan vuld be Menta arkad atic ev	Hector Bustillo				Blanca Z	elaya				
fary 2 sho and 1 is ma	19a. Informant's Name/Relationship (Typ				and Number or Rur					
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if fram 27 is marked other than "natural", or itams 23s or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Ramon Lopez-Rivera, 20a. Method of Disposition	Husband			rt, Rock	Ville,	Marylan 20c. Location			
mor ages ant of in tr. If its	1 ☐ Burial 2 ☒ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dispo cemetery, cre Montgoi	natory or other place	Decem	ber 7,				
altir mit. P oortan / njur	21. Signature of Funeral Service License	011		2. Name and Addre	ss of Facilly Rob	ert A.		y Fune	eral H	lome/
Bal permi Depo- limpo any r	MAX 107	M	.Q689 Ве	thesda-Ch Bethesda.	nevy Chase MD 2081	2, Inc.	7557 W	iscons	sin Av	enue
	23a. Part / Enter the disease, or complice that the complex complex that the complex complex complex that the complex	cations that caused e cause on each line	he death. Do not en	er the mode of dyir	g, such as cardiac	or respiratory a	rre <i>s</i> t,		Approximate Interval Bets	ween
Physician	Immediate Cause (Final disease or condition resulting in death)	_Hepatic	Encephalo	pathy					Onset and C	
/Medical Examiner	resulting in death)	State of the state	consequence of):							
TVC/C	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ge Liver D consequence of):	isease					Week	5
D, b, executed in and ial-transit	trial initiated events	Hepatic	Cirrhosis	(non-alo	oholic)				mont	hs
	resulting in death) Last	Due to (or as a	consequence of):							
687 687 g physicate to g physicate to as the k	d									
P.O. Box 6876in the death certificate be dry the attending physici eleached for use as the but physician/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o		7r			23d. Di	ate of delive	ry	_
Cords, P.O. Box w requires that the death cer been signed by the attendin should be detached for use	in the past 12 months? 1 ☐ Yes 2 🛣 No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		Ectopic pregnancy Other (specify)			М	onth	Day 1	Year
P.O P.O nat the dby the letache	9 ☐ Unknown  Part II. Other significant conditions continuous		A A Min - i - Ab	-4-1	(a D)	on- Did				
d by	Partit. Other significant conditions con	inbuting to death but	t not resulting in the u	ndenying cause giv	en in Part I.		tobacco use cor Yes 2₺∑No			
Il Records, P.O The law requires that the page 2 should be detache.						24a. Was	an 24b.	Were autor	sv findings a	available
Vital Reconfician: The law certificate has rector, page 2				<u> </u>		auto perfo	ormed?	death?	sy findings an pletion of care	ause of
Vital Vital ician: J sector, p	25. Was case referred to medical examiner?		·		26. Place of Deat			103	20110	
of Vita  of Vita  Physician: this certific ral director,	1 ☐ Yes 2X No		t 2 ER/Outpatier		4 Liversing / ic				Hosp	ice
ding Physical ding Total ding Tion; To	27. Manner of Death  1 ②Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor	/ at k? Yes 2 □ No	28d. Describe	how injury occu	rred		
Division of training P reader death.  al Director: After led in by the funers Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	ry - At home, farm, str				Street and Num	ber or Rural	Route Numi	ber,
Div talor safte al Dire ed in 1	4 nornicide	building, etc.	(Specity)			City or To	wn, State)			
he Hospi in 24 hou ha 5-unar pletely fill edical	29a. Certifier 1∑ Certifying Phys (Check only one) 2 Medicel Examin	icien: To the best of er: On the basis of e and manner state	examination and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as sta and due to	ited. the cause(s)	)
To t within To th	29b. Signature and title of certifier	1	P -	29c. Licenso D09			29d. Date signe			
- in	C - V.				₩/U		Decembe	er 4,	2004	
()	30. Name and address of person who cor Eugene P. Libre, M.			•	, Kensing	gton. Ma	arvland	20895		
State Registrar	31. Date filed (Month, Day, Year) DEC 0 6 2004			Spals		,, .16				

State of Maryland / Department of Health and Mental Hygiere 38667 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $\frac{2}{2}$ 3. Time of Death Physician Phyllis H. Luckenbaugh December 2004 1:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 6014 McKinley Street Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
April 16, 1 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F Director 215-56-6784 54 Maryland Usual Residence of Decedent the Maryland wode 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other then "natural", or items 23e or 28e-f ehovevent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6014 McKinley Street 20817 United States death Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse/Educator Hospital 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Heart: If item 27 is marked other. Louis J. Reynolds Pauline V. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul E. Luckenbaugh/Husband 6014 McKinley Street, Bethesda, Maryland 20817 other 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State December 5, 1 ☐ Burial 2 Ø Cremation 3 ☐ Removal from State ö tment c 1 4 ☐ Donation 5 ☐ Other (Specify) 2004 Bethesda, Maryland Crematorium, Inc. permit.
Departr
Import
any inju 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Glioblastoma Multiforme 6 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit certificate be executed Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical the as IF FEMALE: **BSD** 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown 9 ☐ Unknown ۾ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate 1 Yes 2K No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification Division 1 Natural 5 Pending investigation 1 Tes 2 🗌 No 2 Accident completely filled in by the I Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel within 24 hours a To the Funerel C Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signalure and title of 29c. License number 29d. Date signed (Month, Day, Year) D54378 December 3, 2004 Ŋ 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 2730 University Blvd. West, Wheaton, Maryland 20902 Cheryl A. Aylesworth, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

			1- State Unpend Iter Registrar	State of Ma 23a, pt.11	rylan ,27,	d / Depa 28a – P	artment of per me	Health12ng Death		en <b>e</b> () (	) 4	384	68			
	Physici /Medio		Decedent's Name (First, Middle, La STEVEN	JAY		LEVIN		2. Date of Death Month NOVEMBER	Day 29, 2		3. Time of D 9:44a	Death M				
	Examir Funeral	ier	4a. Facility Name (If not institution, given 3601 FORDS LANE A)  5. Social Security Number 6. S	PT 324  Sex 7. Age		last birthday)			rs. 8. Date of Birth	4c. County		N/A	Foreign			
	Director		217-80-1348  Usual Residence of Decedent  10a. State 10b. County	1 M 2 □ F	39	Yrs. y, Town or Lo		, riours	MAY 21,1	1965		Od. Inside City	Limite			
	he Maryla 8e-f shor	Director		/A	roc. on	y, 10wn or Ec		BALTIMO		1 X Yes 2 No						
	Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mental Hygiene. Int: if Itam 27 is marked other then "natural", or Itame 23a or 28e-f show int: if Itam 27 is marked other then "natural", or Itame 23a or 28e-f show into other traumatic event, Ita Medical Example must be untilled at	ral Dire	3601 FORDS LANE #324			10f. Zip Code	21215	g. Citizen of \		USA						
036		by Funeral	11. Marital Status 1 💢 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 💢 N	(Specify Yes or No- erto Rican, etc.)	14. Rac Blac Specify	ean Indian, etc. WHITE							
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Maryland		To Be C	17. Father's Name (First, Middle, Last ARNOLD	)		LEVIN		18. Mother's N	lame <i>(First, Middle, M</i>	Maiden Sumame) BANE						
			19a. Informant's Name/Relationship (	Type, Print) FATHER					Rural Route Number, - BALTIMO			·				
altimore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci		0	emetery, crei	sition (Name of natory or other p		Date 2	oc. Location - BALT		own, State E, MD				
Balti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice	To att	h				OL LEVINSO ROAD - PI				)8			
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	Θ.				iac or respiratory arres			Approximate Interval Betwee Onset and De				
	Certificate be executed Agam Ading physician and use as the burial-transit	dical Examiner				Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b	a consequ	uence of						A. A.	
.O. Box 6	atter for u	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								Date of delivery Month Day Year					
σ.	The law requires that the de ate has been signed by the a page 2 should be detached	by P	Part II. Other significant conditions Seizure Disorder	contributing to death bu	ut not resu	ulting in the u	nderlying cause o	given in Part I.	23e. Did toba	_	ribute to th	ne cause of dea				
Vital Records		Completed							24a. Was an autopsy perform 1 Yes 2	, r	Were auto prior to con leath? Yes	psy findings av npletion of cau 2 No	railable ise of			
of Vita	Phyaicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  XXYes 2 No	Hospital: 1  Inpatie	nt 2 🗆	ER/Outpatier	IL JUDON	26. Place of D	ce 6 AOth							
	ding h. After fune	atlon	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	11 - 74-14	Year)	Found 9:00	W	uryat ork? ⊒Yes 2 <b>X</b> ⊒No	28d. Describe how	28d. Describe how injury occurred <b>unk</b> 28f. Location (Street and Ayyropy or Sural Route Yumber, City or Town, State) 3001 Fords Lane altimore, Md						
Division	D it o	Certiflo	3 Suicide 6 ACould not to determined	28e. Place of Inju- building, etc Found a	: (Specify	/)	eet, factory, offic	9	28f. Location (Stre City or Town, Baltimore							
	tie Hospitel hi 24 hours a tie Funerel nide ely filled	dical	29a. Certifier  (Check only one)  1 ☐ Certifying Pi  XX Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examina	wledge, deati tion and/or in	h occurred at the vestigation, in my	time, date and pla opinion, death oc	ce, and due to the car curred at the time, dat	use(s) and ma e and place, a	nner as si and due to	ated. the cause(s)				
•	To the within To the company of the	Ä	29b. Signature and title of certifier	ronica	· Pe	Dan.		nse number ME	1	d. Date signed						
-			30. Name and address of person who	completed pause of de	eath (Item			TREET, B	ALTIMORE,	MARY <u>L</u> A	ND 2	1201				
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			1- State of Maryland / Departr		
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	/Medi		ATTIVE TOTAL DIS	Nov	1 10 22 0 11
4	Exami	ner		. City, Town, or Location of Death	4c. County of Death
				Salbreve Under 1 Year   If Under 24 Hrs.   8 Date	N/A
	Funeral Director			onths Days Hours Min. (Month	of Birth th, Day, Year)  9. Birthplace (State or Foreign Country)
			Usuel Residence of Decedent		-4/ N.C.
	anylar show	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Be-f	ecto	Md. NA Baltimo		1. Yes 2 □ No
	with t	Dİ	10e. Street and Number 1102 N. Carey Street	Of. Zip Code	10g. Citizen of What Country?
	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28e-f show ont, the M-dical Examiner must be multiled at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21217	or No- 14. Race - American Indian,
(0	r Iter	Fun	Armed Forces? If Yes 1 Yes 2 Xivo	Decedent of Hispanic Origin? (Specify Yess, specify Cuban, Mexican, Puerto Rican, etc.)	C.) Black, White, etc.
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ore,	as 1 a of He of He litem		20a. Method of Disposition 20b. Place of Disposition	(Name of Date	20c. Location - City or Town, State
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Baltimore,	permit. Pages 1 and Department of Healt Importent; If item 2 eny injury or other <u>Qnce</u> .		-13	me and Address of Facility	Baltimore, Md. 21202
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0,	/Medical Examiner	Examiner	Due to (or as a consequence of):	Coronary Diseas	Onset and Death
O. Box 68760,	death certificate e attending phys d for use as the	Completed by Physiclan/Medical		pic pregnancy er (specify)	23d. Date of delivery  Month Day Year
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	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
)			1 hapt & grand ino	D0062183	12/01/04
	n		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Bailimore Street
_	U		Emergency Depart	ment Baltimore,	Manyland 21223
	Sta Registr	1	31. Date filed (Month, Day, Year)  BEC 0 6 2004  Sequence 49	long of	

			1- State of Maryland / Dep Registrar Co	partment of Health and ertificate of Death		iene eg. No. 200	38470
	Physici		1. Decedent's Name (First, Middle, Last) Charles Mattison		2. Date of Deat Month NOV 29		3. Time of Death 1:07PM M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	ith	4c. County of Dea	ath
_		*	Memorial Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Cumberland  If Under 1 Year   If Under 24 Hr	s. 8. Date of Birth	Allegany	theless (State or Foreign
	Funeral Director		212-28-5126 12 M 2 F 73 Yrs.	Months Days Hours Min		Year) C	nthplace (State or Foreign ountry) Yland
	put &		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location			10d. Inside City Limits
	Maryla a-f sho	ctor	Maryland Carroll	Hamps:	tead		1 ☐ Yes 2X No
	with the	Dire	10e. Street and Number 3010 Coon Club Road	10f. Zip Code 21074		0g. Citizen of What C	ountry?
	leath v	eral				USA 14. Race - Am	erican Indian.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23e or 28e-f show any highty or other traumatic avant, the Medical Evantant must be notified at anone.	by Funeral Director	Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No  If Yes, Give  Year or Dates:	. Was Decedent of Hispanic Origin? (. If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	rto Rican, etc.)	Black, Whi	
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ylar	ould be Menta arkad atic av	To B	Samuel Roland Mattison	Mar	ie Evelyn	Helmpker	
, Maryland	s 1 and 2 sho of Health and itam 27 is my other traum		· ·	iling Address (Street and Number or F 110 Coon Club Road			
Baltimore,	ages 1 a ant of He nt: If itam y or othe		1XI Burial 2 Cremation 3 Removal from State	ematory or other place)	O3/2004	20c. Location - City of Sykesvil	
Baltir	permit. F Departme Importar any injur			22. Name and Address of Facility 934 South Main S	Eline Fu	neral Home	2
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)  accromany artery he Due to (or as a consequence of):	art disease			Uk yrs
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	04	eath (Check only one		
ot	dis ya	lon: To	Yes 2 □ No	of 28c. Injury at Work?	Home 5 Reside 28d. Describe ho	nce 6 Other (Spe w injury occurred	ecify)
Division	I or Attending after death. Diractor: After in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Str. City or Town	reet and Number or R , State)	ural Route Number,
П	Hospital	edical Ce	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, deal control one)  29a. Certifier (Check only 2 Medica) Exeminer: On the basis of examination and/or one)  29a. Certifier	ath occurred at the time, date and plac investigation, in my opinion, death occ	e, and due to the ca curred at the time, da	use(s) and manner a ate and place, and due	s stated. e to the cause(s)
	To the Vithin 2 To the	Mec	29b. Signature and title of certifier	29c. License number 09157		ov 29 2004	
•	1		30. Name and address of person who completed cause of death (Item 23a) (Type				-
	of		Paul Snow M.D. Dpty Med Ex 124 W 3rd		502		
	Sta Registr		31. Date filed (Month Early Year) 6 2004 32. Registrar's Signature	Sporks			

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_						38471
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	
	/Medic Examin		ANTHONY MOORE  4a. Facility Name (If not institution, give street and number) Mercy Hospital  4b. City, Town, or Location of Death Baltimore	<del></del>	4c. County of De	1002 a <sup>M</sup>
9	Funeral Director		5. Social Security Number  6. Sex 1 X M 2 F 7. Age (In yrs. last birthday) Yrs.  7. Age (In yrs. last birthday) Yrs.  1 Year If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, 9-20-19		irthplace (State or Foreign Country) MD
	yland sow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	with the Maryland is or 28e-1 show	ctor	MD HARFORD BELAIR			1X Yes 2 □ No
	with th	Dire	10e. Street and Number 10f. Zip Code	10	g. Citizen of What C	Country?
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920	after or ite	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, 2 No If Yes, 3 No If Yes, 3 No Year or Dates:  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes, 3 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Arr Black, Wh	
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	Sb. Kind of Busines	
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S	nd 2 shouth and 27 is ma			LAIR, MAF		
Je,	ss 1 and of Health item 27		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	0c. Location - City o	r Town, State
Ë	Pages ment of I ent: If its ury or o		TEXBURAL 2 Cremation 3 Chemoval from State	7-2004	BALTIMO	RE, MARYLAND
Baltimore,	permit. Pages Department of Importent: If i eny injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility JAM  21. Signature of Funeral Service Licensee  22. Name and Address of Facility JAM  23. Name and Address of Facility JAM  24. Name and Address of Facility JAM  25. Name and Address of Facility JAM  26. Name and Address of Facility JAM  27. Name and Address of Facility JAM  28. Name and Address of Facility JAM  29. Name and Address of Facility JAM  29. Name and Address of Facility JAM  20. Name and Address of Facility JAM  21. Signature of Funeral Service Licensee	. BALTIM	ORE, MAR	NS F.H.,INC. YLAND 21217
	Physician /Medical Examiner		23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cardiomyopathy Of Chronic Renal Discussion of the property of the proper		t,	Approximate Interval Between Onset and Death
,092	eath certificate be executed attending physician and for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.			
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rds, P	w requires that the s been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o the cause of death? robably 4 🖄 nknown
I Records,	e law has b	Completed		24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
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Division	after deal	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the causered at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within to the comp		29b. Signature and title of certifier  OCME	D	. Date signed (Moni ecember 2	, 2004
	a day		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street	,Baltimor	e, MD 212	01
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature			

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Examiner   Liberty Assisted Living   Assisted   Assisted				Margaret	Agnes		McN	air			Decemb	er 3	, 200'4"	8:3	20 A <sup>M</sup>
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Severe Multiple Infarction Dementia    Severe Multiple Infarction Dementia		acuted .nd transit	amir	Cause (Disease or injury that initiated events	C			n							
FEMALE   23b. Was decedent pregnant in the past 12 months?   1   1   2   1   2   1   2   2   2   2	,092	e be exe sician a e burial-		resulting in death, cast				farcti	on De	ementia					
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to be the policy of the policy	on of	ing Phys	-	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injun (Month, Day	/	28b. Time of	280	. Injury at Work?	2				CHYSTSL LIVI	ing
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certified  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Susan J. Miller, M.D., 6844 Tulip Hill Terrace, Bethesda, Maryland 20816  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature	ivisi	or Atten fter deal firector: n by the	rtifica	3 Suicide 6 Could not be	28e. Place of Inju			eet, factory, o						ural Route Num	ber,
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D35579  December 03, 2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Susan J. Miller, M.D., 6844 Tulip Hill Terrace, Bethesda, Maryland 20816  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		he Hos in 24 h he Fun pletely	edica	(Check only 2   Medical Exam	niner: On the basis of	examinat	ion and/or inv	estigation, in	my opinio	n, death occurre	d at the time,	date and	place, and due	to the cause(s	)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Susan J. Miller, M.D., 6844 Tulip Hill Terrace, Bethesda, Maryland 20816  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		To T To 1	Σ	29b. Signature and title of certified	1	>				mber					
Susan J. Miller, M.D., 6844 Tulip Hill Terrace, Bethesda, Maryland 20816  State  State  State  State  State  State  Susan J. Miller, M.D., 6844 Tulip Hill Terrace, Bethesda, Maryland 20816		100		1111		-d- 41:			35579			Dece	mber 03	3, 2004	
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			_		32. Registra	r's Signat	lure 4	done	21						

MORRISON, WILLIAM Division of Vital Records, P.O. Box 68760,

Dhysia	2.5	1- State of Maryland / Departmen Registrar AMEND TTFM #10e&19b PER ana Signal  1. Decedent's Name (First, Middle, Last)		•	Reg. No.	38 Ly
Physic /Medi		William H. Morrison		DECEM	ber 1 2	8111 Poo
Examir	ner		Town, or Location of Death  AS TON	h	4c. County	of Death
Funeral Director		5. Social Security Number 217−16−0474	* .	8. Date of Bir (Month, Da Sept 22	th	9. Birthplace (State or Country) Pennsylvar
show	2	Usual Residence of Decedent  10a. State				10d. Inside Cit
or 28a-f	Director	MD Caroline Denton  10e. Street and Number 10f. Zip	Code		10g. Citizen of V	1 ☐ Yes What Country?
ms 23a	neral [	25/256 FIOTI Road  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	21629 dent of Hispanic Origin? (S	pecify Yes or No	- 14. Rac	USA e - American Indian,
rai', or ite Exartine	by Funeral	Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  Armed Forces?  1 NYes 2 No If Yes, Give Year or Dates: 42-45	cify Cuban, Mexican, Puèrti 2 <mark>X</mark> No <i>Specify:</i>	o Rican, etc.)	Spec ify	ck, White, etc. white
ene. than "natu the Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	rk done during most of wor.	king	16b. Kind of Bu	usiness/Industry
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Mental harked of	To Be	Harold Konover Morrison	Lillian			16)
Department of Health and Mental Hygjene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Enal: it writings be indified at any injury or other traumatics.		Doris Morrison/spouse 26256 Lio  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State	Street and Number or Ru ME Road Dento me of ther place)	on, MD 2 Date	1629	State, Zip Code)  City or Town, State
Department of Important: If any injury or once.		21. Sign trie Funeral Serve Licensee S. Wade Director State A	d Address of Facility	4 655 U	D - 164	
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Medical aminer	Examiner		ore, MD 2120	JΙ		Approximate Interval Betw
	m	Baltimo  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, one and failure. List only one cause in each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events of the conditions of the cause of the c	ore, MD 2120	JΙ		Approximate Interval Betw
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	Physic /Medi	cal	1. Decedent's Name (First, Middle, La	moRGA~		45 675 7		2. Date of De Month	Day	Year Ol/	3. Time of Death
	Examii Funeral	ner	4a. Facility Name (If not institution, give Policy Name (If not institution, give Policy Name (If not institution, give Policy Name (If not institution, give Policy Name (If not institution, give Policy Name (If not institution, give Policy Name (If not institution, give Policy Name (If not institution, give Policy Name (If not institution, give Policy Name (If not institution, give Policy Name (If not institution, give Policy Name (If not institution, give Policy Name (If not institution, give Policy Name (If not institution), give Policy Name (If not insti	J RELIAN 7. AS	ge (In yrs. last birthd.	SAid ay) If Under 1 Year	SBURY If Under 24 Hrs	8. 8 Date of Bir	th	9. Birthp	place (State or Foreign
	Director		227-24-1577  Usual Residence of Decedent  10a. State 10b. County	1□ M 2∏ F	79 Yrs		Hours Min	Apr 7,	1925		ginia
	the Maryla 286-f ehov	rector		omico	Too. City, Town of	Salisbury			10g. Citizen of		0d. Inside City Limits  1 □ Yes 2√√ No
	within 72 hours atter death with the Maryland ene. than "natural", or Items 23a or 28e-f show he Mcdiffal Exp. "Itel", and be nutilised at	Funeral Director	105 Times Squar	12. Was Decedent Armed Forces	7	Was Decedent of H     If Yes, specify Cub.	21801 lispanic Origin? (S an, Mexican, Puer	Specify Yes or No	- 14. Rad	JSA ce - Americ ck, White,	an Indian,
5-0036	2 hours atte	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced  15. Decedent's E		16a. De	1 ☐ Yes 2X No	Specify:	unk	Specif		ite dustry unk
12121	led within 7 lygiene. her than "n	Completed	(Specify only highest grandless of the secondary (0-12)  5  17. Father's Name (First, Middle, Last	College (1-4or	life	ive kind of work done  a. DO NOT use retired					
Maryland 21215-0036	should be find the property of marked of imatic even	To Be	John Watson  19a. Informant's Name/Relationship (		19b. Ma	ailing Address (Street	Mag	me (First, Middle, ggie Budd ural Route Numbe	d		Code)
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-f ehow any injury or other traumatic event, the Medical Expedition 1: Interview to other traumatic event, the Medical Expedition 1: Interview to multised at once.		Anchorage Nursin  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 ☒ Donation 5 □ Other (Special	Removal from State	20b. Place of Dis	Times Squ sposition (Name of rematory or other place	are Sali				
Balti	permit. Departm Imports eny inju		21. Signature of Euneral Service Lice	// /NIVU		22. Name and Addre State Anat Baltimore,	omy Boar MD 212			ore S	treet
8760,	Physician / Medical Examiner physician and physician and the purial-transit	dical Examiner	23a. Pant. Enter the disease, or comshock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, heading to mathediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. ASC Due to (or as	ne.		y, such as carda	с от теарпатоту ат	1951,		Approximate Interval Between Onset and Death
P.O. Box 687	death certifi e attending d for use as	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Da	te of deliver	ry Day Year
Ś	The law requires that the ate has been signed by the page 2 should be detache		Part II. Other significant conditions of	contributing to death b	out not resulting in the	underlying cause giv	en in Part I.				e cause of death?
Vital Record	: The law recate has be-	Completed	1						rmed2	Were autoporior to combeath?	osy findings available apletion of cause of
ot	nding Physician: The l th. : Atter this certificate ha s tuneral director, page.	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ent 2 ER/Outpat iry y Yeer) 28b. Time Injury	of 28c. Injun	er: 4 Nursing H	ath (Check only or dome 5 \subseteq Resid 28d. Describe h	lence 6 🗆 Oth		)
Divis	To the Hospitel or Attending I within 24 hours atter death.  To the Funerel Director: Atter completely filled in by the tuner	Certification:	3 Suicide 6 Could not b 4 Homicide determined	280. Place of Inj	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (S City or Tow	Street and Numb m, State)	er or Rural	Route Number,
	the Hospi nin 24 hou the Funer npletely fill	ledical	one)	nysician: To the best niner: On the basis o and manner st	t examination and/or	investigation, in my o	oinion, death occu	irred at the time, o	date and place, a	and due to	the cause(s)
)	To To	W	29b. Signature and title of certifier				47094			15/0	4
	Sta	ite	30. Name and address of person who  VEL NATESAN  31. Date filed (Month, Day, Year)	32. Registr		Spartn	57.1	Sti	ISAURY	, 17	02,804
	Registi	ar	DEC 0 6 2004	Care.	in G	Doutes					

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of I rtificate of			giene Reg. N2 0 0 4	38475
	Physic	ian	Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month	ith Day Year	3. Time of Death
	/Medi		Joseph		Meni	nger		Decembe		12:35 A <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, o	or Location of Death	1	4c. County of Death	1
			3003 Moreland	Avenue			kville_		Baltimor	re e
	Funeral			Sex 7. Ag 11☑M 2□F	e (In yrs. last birthday) Q Q Yrs.	If Under 1 Year Months Days		(Month, Day	9. Birth	nplace (State or Foreign untry)
	Director		213-18-0102 Usual Residence of Decedent		83 Yrs.			11/24/		ryland
	land land		10a. State 10b. County		10c. City, Town or Lo	ocation			- T	10d. Inside City Limits
	Mary	ğ	MD Baltin	ore	Parkvi]					1 □Yes 2 XNo
	ith the Marylar or 28a-f show	Je C	10e. Street and Number			10f. Zip Code			log. Citizen of What Cou	intn/2
	3a o	D	3003 Moreland Ave	nue			234		U.S.A.	
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examinational by Indified at	Funeral Director	11. Marital Status	12. Was Decedent I	Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-		ican Indian,
9	after or Ite	Ē	1 Never Married 2 Married	Armed Forces?	10			o Rican, etc.)	Black, White	
5-0036	ral',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify: Wh:	ite
5-0	72 h natu dical	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup	pation during most of wor	king	16b. Kind of Business/li	ndustry
2121	ithin ne.	ldu	Elementary/Secondary (0-12)	College (1-4or 5	+)		during most of word d)	9		
	filed within Hygiene. Ither than "	S	12		Car	penter			Home Buile	ler
and	ould be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, Last						Maiden Sumame)	
3	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, In Me	Lo	Leonard Meninger				Martha		zkowski	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryla 1 of Health and Mental Hyglene. If item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, The Medical Exch. Activity to a collical and other traumatic event.		19a. Informant's Name/Relationship ( Naomi Meninger /	**					, City or Town, State, Zi	
	s 1 and of Health item 27 other tr		20a. Method of Disposition	wile					e, Maryland	
Baltimore,	Pages nent of h int: If ite		1 Burial 2 Cremation 3		20b. Place of Dispo cemetery, cres		1	- 1	20c. Location - City or T	own, State
ţ	+ 5 th 15		'4 Donation 5 Dother (Special			of Faith		6/04 B	altimore, N	laryland
Bal	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Licer	15		2. Name and Addre	111	ller-Dip	pel Funeral	Home Inc.
			23a. Part1. Enter the disease, or orm shock, or heart failure. List only			415 Bela:	ir Road B	altimore	. Maryland	21206 Approximate
8760,	Projection and /Medical Examiner  the prijar-Itansit it project of	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Security lateralities if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):  Cinyast a consequence of):  Remail a consequence of):	Forter	ndiom ine m sculen	yoza yoza ild Siseer	the :	onset and Death Syno Syno Syno Syno
.O. Box 6	the death certific by the attending p ached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	,		23d. Date of delive	ery Day Year
s, P	res that igned b	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to the	he cause of death?
ğ	w require been sig should b		Smile Done	Fen Vasi	utern an	& Aloche	mes o	1 2 10	s 2 No 3 Prob	ably 4 □Unknown
Vital Record	e law re has be je 2 sho	Completed	Type: Present	al mulm	moren	Dunda	10	24a. Was ar		ipsy findings available
m	The laste has page.	E O	Nuhretnkust	rector	How Orke	SARILA	2	autopsy	ed? death?	mpletion of cause of
ita	iician: T certificat rector, pa	0	25. Was case referred to medical		2009	J. Jawa	26. Place of Deat			2 □ No
_ <	d is	To B	examiner? 1 Tes 2 No	Hospital. I Inpatier	nt 2 ER/Outpatien	t 3 DOA Othe			nce 6 Other (Specific	iv)
J of	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury Work		28d. Describe ho		.,
Division	Attanding r death. sctor: After by the funer	Certification;	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		roar) injury		Yes 2 □ No			
Vis	I or Attan after deat Diractor: I in by the	tiffic	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, stre	eet, factory, office		28f. Location (Str.	eet and Number or Rura	I Route Number,
	s after s al Dira	Cer		building, etc.	(Specify)			City or Town,	, State)	
	To the Hospital or Al within 24 hours after of To the Funeral Dirac completely filled in by	edical	29a. Certifier 1	ysician: To the best of niner: On the basis of and manner stat	examination and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as si te and place, and due to	ated. the cause(s)
	To the within 2 To the Complet	Σ	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Month,	Day, Year)
)			Michelo	Me	ny	1300	2769	3	12/3/0	4
٠,	3		30. Name and address of person who	comp sted cau e of de	ath (Item 23a) (Type, F				, = , =	,
	١*		MICHAEL	HTLEN	20- 65	30 W D 27	HERAVE	E., 1544	Te, Md. 212	.66
	Sta Registr	2	31. Date filed (Month Day Year) 6	32. Registrat	r's Signature	don	V. 1			

			1 - For State Registrar	State of	Maryland / Dep	artment of i		nd Mental Hy	rgiene	1 20176
	Physic		Decedent's Name (First, Middle     Charles	, Last)		acNeal		2. Date of De Month Decembe	Day Ye	
	/Medi Exami		4a. Facility Name (If not institution Genesis Elderca		ber)	4b. City, Town, Baltimo			4c. County of D	Death
	, Funeral Director		5. Social Security Number 217–09–1540		. Age (In yrs. last birthday, 84 Yrs.	If Under 1 Year Months Days		8. Date of Bit (Month, Date 4/3/19	rth ay, Year) 9.	Birthplace (State or Foreign Country) [aryland]
	e Maryland 3a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Balt	imore	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	eath with the	Funeral Director	10e. Street and Number 218 Marion Av			10f. Zip Code 212	<del> </del>		10g. Citizen of What U.S.A.	•
9036	be filed within 72 hours after death with the Maryland hat Hygiene. ad other then "naturel", or Items 23c or 28a-f show event. The Modical Exertituer restor for Items at	þ	11. Marital Status 1 □ Never Married 2 ★ Marri 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Forc ied 1 Tyes 2 If Yes, Give Year or Date	es?	Was Decedent of lif Yes, specify Cub		n? (Specify Yes or No Puerto Rican, etc.)	14. Hace - A Black, W Specify:	unerican Indian, Thite, etc. White
Maryland 21215-0036	I within 72 h iene. r <b>then "nat</b> u Ibs Modical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education tt grade completed) College (1-4	(Give life.	dent's Usual Occu kind of work done DO NOT use retire	durina most c	of working	16b. Kind of Busine Meat Com	
yland 2	12 should be filled within h and Mental Hygiene. 7 Is marked other then "treumatic event, It's Way	To Be C	17. Father's Name (First, Middle, William MacNeal	Last)	, onta			s Name (First, Middle Linthicum		рапу
Baltimore, Mary	of Healt fitem 2 r other		Martha A. MacNe  20a. Method of Disposition  1 □ Burial 253Cremation  4 □ Donation 5 □ Other (Sp.	eal/Wife	218 20b. Place of Dispo	Marion a sition (Name of matory or other pla	Avenue	Balto. Ma	er, City or Town, State  ryland 212  20c. Location - City	or Town, State
Baltir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service I	icensee Jane	De Magaza	2. Name and Addre	ess of Facility	1		ral Home Inc. nd 21206
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_ a h	as a Insequence of):	Dech	ing, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of,  Congrature as a consequence of):  Annum	Sorlla Hea	tion ut	Ad Baltimor		
.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		me of pregnancy  1 2 Fetal death 3 that time of death 5 to	Ectopic pregnanc			23d. Date of o	delivery Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant condition	ns contributing to deat	th but not resulting in the u	nderlying cause giv	ven in Part I.	1		o to the cause of death? Probably 4 <sup>€</sup> ∭Unknown
al Records,	The ate h	Completed								
ion of Vital	Attending Physician: r death. ector: After this certific by the funeral director,	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 Manner of Death  1 Matural 5 Pending investig			28c. Injur Wor	ner: 4 🖰 Nursi	28d. Describe h	ne) dence 6 □Other (Sp now injury occurred	эвсіfy)
Division	in Diffe	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of building,	Injury - At home, farm, str , etc. (Specify)			City or Tow	,	
	To the Hospitel of within 24 hours a To the Funerel Completely filled in	Medical	29a. Certifier (Check only one)  2 Medical E	Physicien: To the be xaminer: On the basi and manner	est of my knowledge, death s of examination and/or in stated.	occurred at the tirvestigation, in my o	opinion, death	occurred at the time,	date and place, and d	ue to the cause(s)
	7 3 5 8		30. Name and address of person v	the completed cause	M i)	D	3146	4	1243(8	4
	\1 Sta	to	SHOAIJ A  31. Date filed (Month, Pay, Year)	HAJI 32. Regi	istar's Signature	N. En	law	or Int	Z30P13	21201
12	Sta Registr		DEC 0	5 2004	server for	Span	Kal			

R	J		For State	State of Mar		artment of He			211114	38477
			1. Decedent's Name (First, Middle, Las	")		Tuncate of L	Jealii	Reg. 2. Date of Death	No.	3. Time of Death
	Physici /Medi		Marc W. No	ove11o					Day Year 1. 2004	01:25A M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of Death	n
			20576 STRATH HAVE			MONTGOMER			MONTGOMER	Y COUNTY
	Funeral Director		114-60-6786	x 7. Age (	In yrs. last birthday,	If Under 1 Year     Months   Days	Hours Min.	8. Date of Birth (Month, Day, Ye July 30, 1	9. Birth Col New	nplace (State or Foreign untry) York
	/land		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Limits
	Many B-feh	tor	Maryland Montgor	nerv	Montgome	ery Villag	e			1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	untry?
	ath w		20576 Strath Have			2088			U.S.A.	
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow diest Evantiner must be rediffed a	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🖾 No	panic Origin? (Spe , Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
9	2 hou		15. Decedent's Edu	ıcation	16a. Dece	dent's Usual Occupat	tion	16b	. Kind of Business/le	
Maryland 21215-0036	within ene. then *	Completed	(Specify only highest grad	College (1-4or 5+)	life.	kind of work done du DO NDT use retired) ecret Serv		ng .		1 Government
102	Hyge #	a	17. Father's Name (First, Middle, Last)		05 56			(First, Middle, Maid		1 Government
/lar	should be nd Mental marked o umatic eve	To B	William Novello				Joyce Be	hm		
lan	2 should to and Ment is marked eumatic e		19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Maili	ng Address (Street ar	nd Number or Rural	Route Number, Cit	y or Town, State, Zi	ip Code)
	s 1 and 2 should of Health and Mer item 27 is marke other treumatic		Elizabeth A. Nove							e, MD 20886
Baltimore,	0 0		20a. Method of Disposition  1   Burial 2 □ Cremation 3   '4 □ Donation 5 □ Other (Specify)	Removal from State		ostion (Name or matory or other place) irk Cemete:	)		Location - City or T ndleton, 1	
Balt	permit. Pag Department Importent: I eny injury o		21. Signatury of Funeral Service Licens	oo MULA MX	5 21 64	2. Name and Address Iiller-Dip 15 Belair	of Facility pe1 Funer Road Ba1	al Home,	Inc.	21206
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the	e death. Do not ent	er the mode of dying,	such as cardiac or	respiratory arrest	7	Approximate Interval Between
A	Physician (Madical		Immediate Cause (Final disease or condition resulting in death)	Contai	t gum	lot of	1 the	head		Onset and Death
	/Medical Examiner			Due to (or as a c	ons- (unice of):	,				
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):					
	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
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.O. Box	that the death certifed by the attending detached for use a	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
s, P.	that the ned by detac	by Ph	Part II. Other significant conditions con	ntributing to death but n	ot resulting in the u	nderlying cause given	in Part I.	23e. Did tobacco	o use contribute to ti	he cause of death?
ords	w requires that s been signed t should be det	ted b						1 ☐ Yes	2 XNo 3 □ Prob	oably 4 Unknown
Vital Record	The la	Completed						24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
Ĭ.	sician certifi rector	o Be	25. Was case referred to medical examiner?	lospital:		Dahaa	26. Place of Death			AT SCENE
0	g Phy er this eral d	-	27. Manner of Death	28a. Date of Injury	20h Ti	I 3LI DOA	4   Nursing Hom	e 5 Residence	4.44	y) AT SCENE
ion	ath. ath. or: Afte	atlo	1 □ Natural 5 □ Pending 2 □ Accident investigation	Four 12-1-C	T40 T / APV		s 2 No	reseased	Shot A	elf
Division of	or Atte	Certification;	3 Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	Chaoini) i		28	If. Location (Street a	and Number or Rura	Strath Hanle
Ω	urs af urs af arel D			1	140M		D	rive. Mew	topuen Vi	Hage, MD
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certifice completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physical Examination	sician: To the best of m ner: On the basis of ex- and manner stated	amination and/or inv	occurred at the time, restigation, in my opin	date and place, an lion, death occurred	d due to the cause( I at the time, date a	sy and manner as si nd place, and due to	tated. the cause(s)
)	To t with To t	Σ	29b. Signature and title of certifier	M		29c. License n OCME	umber	DEC	eate signed (Month, CEMBER 1,	2004
١	0	1	30. Name and address of person who co	mpleted cause of death		CNN STREET	. BALTIMO	RE, MARYI	AND 21201	
	Sta Registra	te ar	31. Date filed (Month Day Year) 6 2	32. Registrar's		Spare	•			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Yeer 10:00P M POLL ORE november 29, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL BALTIMORE SON SECOURS NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 12-1-23 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1 M 2 F 238-46-6386 80 **Director** N.C. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other then "natural", or Itema 23a or 28a-f show other traumatic event, the Modical Externities must be notified at 10d. Inside City Limits Director ty∏Yes 2 □ No Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1416 E. Preston Street 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: þ If Yes, Givo Year or Dates: Specify: 3 ☑ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress 10th grade 17. Father's Name (First, Middle, Last) Walker's Dry Cleaners 18. Mother's Name (First, Middle, Maiden Surname) Be Austin ဂ Graham Rosetta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1416 F. Preston Street, Baltimore, Md. of Disposition (Name of 20c. Location - City Martha Williams Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cem. 12 - 3 - 04Lansdowne, Md. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown 9 🗌 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ∃Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 24a. Was an this certificate has al director, page 2 autopsy performed? res 2 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? 1 - Natural 5 Pendina death. investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 00030355 november 29,2004 30. Name and address of person who completed cause of d ath Item 23a) (Type, Print) BOY SECOURS CRUZ LOSIT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1- For State of Maryland / Dep Registrar	artment of Health and Nartificate of Death	Mental Hygie Reg.		38479
	Physic /Medi		Decedent's Name (First, Middle, Last)  EDWIN  (	)TTENHEIMER	2. Date of Death DECEMBER		3. Time of Death 7:15 A M
	Examir		4a. Facility Name (If not institution, give street and number) BRIGHTWOOD NURSING HOME	4b. City, Town, or Location of Death		4c. County of Death	IMORE
	Funeral Director		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last birthday</i> 1 M 2 □ F 89 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth SEP. 20, 19	9. Births Cour	place (State or Foreign htry) MD
	Maryland f show	or	Usual Residence of Decedent			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a-	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	^
	ha 23e	Funeral	7913 LONG MEADOW ROAD  11. Marital Status  12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispania Origina (Sa	onifu Von es No	14 Boss America	USA
980	ours after or ral', or iten	by	Armed Forces?  1 Never Married 2 Married 1 Yes 2 M No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item a 23 or 28a-f show any injury or other traumatic avant. The Medical Examination investor notified at once.	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	Nind of Business/Ind	dustry
	al Hygi I other	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
Maryland	hould b d Ment markac matic a	To		HEIMER BESSIE			ENBERG
_	and 2 s valth an 127 is er traus			ng Address (Street and Number or Rura LONG MEADOW ROAD			
ore	ages 1 of He : If itan		Mediai 5 Continuion 3 Chemiovalitom State	matory or other place)		. Location - City or To	wn, State
altimore,	permit. Pa Departmer Important any injury		' 4 □ Donation 5 □ Other (Specify)  21. Signature Funeral Service Licensee	OM CEMETERY   12/03 2. Name and Address of Facility SOL	3/2004   EVINSON	REISTERS	TOWN, MD
<u>m</u>	8 2 E 8		skett III. withe 8	900 REISTERSTOWN F	ROAD - PIK	ESVILLE, 1	MD 21208
}	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	er the mode of dying, such as cardiac of Cevebro Vcurcul		trobe	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	es Mellitu			
8760,	icate be executed physician and s the burial-transit	dical Exa	resulting in death) Last  Due to (or as a consequence of):  d.				
9			IF FEMALE: 23c. If yes, outcome of pregnancy				-11
O. Box	at the death certific by the attending p tached for use as	Physician/M	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	y Day Year
ecords, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the unconveyable blooms	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the	
r	The ate his page	Completed	I chemic Heur	2 reene	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ N	prior to com death?	sy findings available pletion of cause of
VITal	sician: certific rector,	o Be (	25. Was case referred to medical examiner?  1 Yes 2 Hospital: 1 Inpatient 2 FR/Outnation	26. Place of Death	(Check only one)		
n or	ding Phys h. After this funeral di	$\vdash$	1   Inpatient   2   ER/Outpatient   27. Manner of Death   28a. Date of Injury   28b. Time of Injury   Injury   28b. Time of Injury	t 3L1 DOA 4 Nursing Hon	ne 5 Residence 8d. Describe how inj	6 □Other (Specify) jury occurred	
UIVISION	al or Attanding after death. I Diractor: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	06 1		
2	ital or At rs after d al Diract led in by	Certi	4 Homicide determined 200. Flace of injury - At home, farm, string building, etc. (Specify)	set, factory, office	City or Town, Sta	and Number or Rural. ate)	Houte Number,
	To the Hospital o within 24 hours aff To tha Funeral Di completely filled in	Medical	29a. Certifier  (Check only one)  1	estigation, in my opinion, death occurre	nd due to the cause( d at the time, date a	(s) and manner as sta nd place, and due to t	ted. he cause(s)
	To Cor	-	29b. Signature and title of certifier	29c. License number		Date signed (Month, Da	
	75		30. Name and address of person who completed cause of death (Item 23a) (Type, 18 20 20 20 20 20 20 20 20 20 20 20 20 20		18W2,	Balkm	ow, ma
	Stat Registra	_	31. Date filed (Month, Day, Year)  DEC 0 6 2004  32. Registrar's Signature	Sporks		-	

			For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of H			giene Reg. No.	004	38480
	Physici.		Decedent's Name (First, Middle, I Saac	Pringle	Jr.			2. Date of De	20 ,200	4 Year	3. Time of Death 12:55pm <sub>M</sub>
	/Medic Examin		4a. Fecility Name (If not institution, gresidence 6453  5. Social Security Number 6	Pennsylvania	a Ave.#T	4b. City, Town, o	t Heigh	ts	Р		olece (State or Foreign
	Funeral Director		Usual Residence of Decedent	Sex 7. Age	6.7 Yrs.	Months Days	Hours Min	n. 03/09/2	1937)	Sumt	er,sc
	h the Maryla rr 28a-f show r notifing at	Director	MD PG  10b. County PG  10e. Street and Number		District	Heights	j		10g. Citizen	of What Cour	0d. Inside City Limits  Y Yes 2 □ No  ntry?
36	2 should be filed within 72 hours atter death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 23a-f show aumatic event, the Modral Exponer count be notified at	Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E	Ever in U.S. 13.	20747 Was Decedent of H If Yes, specify Cubin	lispanic Origin? ( an, Mexican, Pue Specity:	(Specify Yes or No erto Rican, etc.)		Race - Americ Black, White, ecify: B1a	etc.
21215-00	ed within 72 hou ygiene. 'er than "nature t, the Macoloute	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of w		Metro	of Business/Ind	dustry
ryland	ed ita	To Be	17. Father's Name (First, Middle, La Isaac Pringle Sr 19a. Informant's Name/Relationship		19b Mailir	ng Address (Street	Vernel		fy		(Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic once.			daughter)		3 Pennsyl sition (Name of matory or other place	vania A	ve. #T Di	istric		nts,MD 2074
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Lie	9	846	Austrhodr 3821 14t	byster I h St. N	Funeral H Washing	lome gton,DO	C 20011	
\$15 \$20 \$10 \$10 \$10 \$10 \$10 \$10 \$10 \$10 \$10 \$1	Physician /Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	Hypercal	cemia consequence of):	er the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death 2months  5years
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	dicai Examiner	Saturatedly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Diabetes	a consequence of):  Mellitus a consequence of):						10years
O. Box 6	that the death certifica led by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	,		23d.	Date of delive Month	ory Day Year
Records, P.	w requires that been signed I should be det	by	Part II. Other significant condition: Cerebrovascular	Disease	at not resulting in the u	nderlying cause giv	en in Part I.		obacco use d Yes 2□N		ne cause of death?
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Division of Vital	Attending Physician: The in death.  ector: Atter this certificate hiby the funeral director, page	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1. Natural 5 Pending investigal	Hospital: 1  Inpatie 28a. Date of Injur (Month, Day	y 28b. Time of	28c. Injur Wor	er: 4 Nursing	Home 5 Resident Particles Particles I	dence 6 🗆		()
Divis	o diric c	Certification:	3 Suicide 6 Could no determine	ed 288. Place of inju- building, etc				City or Tou	wn, State)		l Route Number,
	To the Hospital within 24 hours a To the Funeral I completely tilled	Medical	29a. Certifier (Check only one)  2 ☐ Medical Ex	Physician: To the best of taminer: On the basis of and manner sta	examination and/or in	occurred at the tirvestigation, in my o	pinion, death occ	curred at the time,	date and place	manner as st ce, and due to gned (Month, i	the cause(s)
	1		30. Name and address of corson wi	Myseum no completed cause of de	eath (Item 23a) (Type,	Print)	9910	CC2 ! -	1//2	9/0	9. C 7001/2
	Sta Registr		31. Date filed (Modifin, Day, Year)	32. Registra	Kenal d	budan, V	TIVIC 1	50 170	1105 Jr	ex, D	C 20042

			1 - For State Registrar	State of Maryland	/ Dep			Mental Hyg	9	
			Decedent's Name (First, Middle, Last	)				2. Date of Dea	th	3. Time of Death
	Physici /Medio		WILLIAM FLE	MMING PARISH	SR			Decembe	r 1, 200	6:45P M
	Examin		4a. Facility Neme (If not institution, give	·		4b. City, Town, o	r Location of Death		4c. County of	Death
			St Joseph Medical			Towso				timore
	Funeral Director		5. Social Security Number 6. Se 214-18-6397	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 11		Birthplace (State or Foreign Country) Maryland
	land ow		10a. State 10b. County	10c. City,	Town or Lo	ocation	· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
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	th the	Funeral Director	10e. Street and Number	7 341	0111101	10f. Zip Code		1	0g. Citizen of Wh	
	23a	a	7100 Ridgeleigh Co	urt		2121	12		USA	
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36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married  3 ★ Widowed 4 ☐ Divorced	1XXYes 2 □ No WW If Yes, Give Year or Dates:		1 □ Yes 💥 No	Specify:		Specify:	White
8	72 hours after death with the Maryland naturel; or Items 23e or 28e-1 show Jical Examiner must be notified at	ed t	15. Decedent's Edu		16a Dece	dent's Usual Occup	nation		16b. Kind of Busi	
715	7 nic 7	plet	(Specify only highest grad	e completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of work d)	ring	TOD. TUITO OF DUSI	nosanidadiy
212	be filed within 72 hours after death with the Marylan at Hygiene. All Hygiene. All then "naturel", or Items 23a or 28e-1 show event, In a Marical Examiner must be rediffed at	Completed	Liementary/Secondary (0-12)	4		Engineer			Manufa	cturing
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yla		Ļ	Oscar Junius Parri			ļ		Brimage		
Maryland 21215-0036	d 2 should th and Mer 7 Is marke traumatic		19a. Informant's Name/Relationship (T)				and Number or Rur			
	1 an Heali em 2 ther		William F Parrish 20a. Method of Disposition				Court T	-	Maryland 20c. Location - Ci	
nor			XX Burial 2 ☐ Cremation 3 ☐ F	emova nom state		sition (Name of matory or other place				
Baltimore,	permit. Page Department of Importent: If any injury or once.		Donation 5 ☐ Other (Specify)  21 signature of Funeral rylice Lights		A COLUMN TO A COLU		ery 12/4			le, Maryland
Ba	Dep Imp		Lowner & Agakon	(Crackes)						eral Home Inc Maryland 21212
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	cations that caused the death. ne cause on each line.	Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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39 )	eath certifica attending ph I for use as th	Med	IF FEMALE:							303
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal d	leath 3	Ectopic pregnancy	,		23d. Date of Month	•
0.	at the de by the a tached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	ıth 5∟	Other (specify)				July 10al
۳.	\$ 8 g		Part II. Other significant conditions con	ntributing to death but not result	ing in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribu	ute to the cause of death?
Division of Vital Records,	w requires been sign should be	ed by	Bronchogenic Carci	noma with Live	r & A	drenal Me	tastases	1 □ Y€	es 2□No 3[	☐ Probably 4\(\)\(\)\(\)\(\)Unknown
900	law requas been 2 shoul	plet	Pericarditis with	Effusion				24a. Was ar autops		re autopsy findings available or to completion of cause of
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of \	\$ 5		1 195 4170	lospital: XX Inpatient 2 El		t 3 DOA Othe	er: 4 🗆 Nursing Ho			(Specify)
ono	ling After une	tlon	27. Manner of Death  1. Watural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	Worl	yat k? Yes 2 □ No	280. Describe no	w injury occurred	
/isi	ten tor: the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str			28f. Location (Sti	reet and Number of	or Rural Route Number,
Ö	in Dir	Certification;	4 I Hollicide					City or Town	, State)	
	0.7 6 7	=	29a. Certifier Certifying Phys	sician: To the best of my knowl ner: On the basis of examinatio	ledge, death on and/or in	occurred at the time	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manne ate and place, and	er as stated. I due to the cause(s)
	the Hospitel in 24 hours and Eunerel pletely filled	edica	(Check only 2 Medical Exemi-	and manner stated.						
	To the Hospitel within 24 hours a To the Funerel completely filled	Medical	(one on ) Z Induical Exemi	and manner stated.		29c. License		29	9d. Date signed (A	
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\	To the Hos within 24 ho To the Fun completely it	Medica	one)	mpleted cause of death (Item 2		29c. License D17	e number		December	Month, Day, Year)

			Please	State of Maryland / Dep		•	•	
		•	For State Registrar		ertificate of Death		g. No. 2004	38482
			1. Decedent's Name (First, Middle, Las	1)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al		Repp	4b. City, Town, or Location of Deat	November	18, 2004 4c. County of Deeth	7:35 P <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, give Washington Adven		A TENERAL STATE			
	Funeral		5. Social Security Number 6. Se		Takoma Park  y) If Under 1 Year   If Under 24 Hrs	8. Date of Birth	Montgomery 9. Birthpleo	e (State or Foreign
2	Director			XM 2□F 97 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, July 21,	1907 Calif	ornia
	yland sow		10a. State 10b. County	10c. City, Town or I	Location		10d	. Inside City Limits
	e Mar	Director	Maryland Prince G	eorge's Hyattsv				1∭ Yes 2 □ No
	with th	Dire	10e. Street and Number		10f. Zip Code		g. Citizen of What Country	1?
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36	d within 72 hours after death with the Maryland jiene. r then "natural", or Iteme 23a or 28a-f ehow the Medical Examinat must be notified at	by Funeral	1 □ Never Married 2 ⅓ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No 11 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer     □ Yes 2 No Specify:	to Rican, etc.)	Black, White, etc	
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Maryland 21215-0036		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired) Salesman		Laundry Indu	otru
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ary	2 should be and Menta le marked aumatic ev	-	19a. Informant's Name/Relationship (7	Type, Print) 19b. Ma	iling Address (Street and Number or Ri	ural Route Number,	City or Town, State, Zip C	ode)
	1 2 mg		Elaine Murphy (D		Calverton Dr., H			
Baltimore,	Pages 1 a nent of Hez int: If Itam iry or otha		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 ☐	Removal from State	rematory or other place)		0c. Location - City or Town	
Ħ		1	*4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen		itan Crematory 11	Control of the Parket Street S	lexandria, V	A
Ba	permit. Departr Imports eny inj		Danie (1	Tillan 100	22 Name and Address of Facility Capitol Funeral S 7211 Lee Highway,	ervice Falls Chu:	rch, VA 2204	2
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death. Do not e	enter the mode of dying, such as cardia	c or respiratory arres	st, A	oproximate nterval Between
	Physician		Immediate Cause (Final disease or condition	ACUTE	140 CAR DIAL	INFA	RCTION S	nset and Death DAY
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	CARDIUMY (	PATH	4 6	420
	And Are	7	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):	00/00/01/00		7	710
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
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68760	rtificate b ng physic as the bi	dica		d			-	
Box 6	certifi nding I use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	_		23d. Date of delivery	
	death cert e attendin ed for use	icia	in the past 12 months?		☐ Other (specify)		Month D	ay Year
P.0	res that the de signed by the a be detached to	Phys	9 Unknown			On- Dida-ba		and a state of death 2
of Vital Records,	The law requires that the death certificate be executed tite has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Completed by	AUR TICE	ontributing to death but not resulting in the	underlying cause given in Part I.	239. Did toba	acco use contribute to the s 2 No 3 ☐ Probab	oly 4 Unknown
eco	law re as bee 2 sho	plet				24a. Was an autopsy	24b. Were autops	y findings available pletion of cause of
- B		Con				perform 1 Yes 2	ed? death?	No
Vita	Physicien: Th this certilicate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Othor	ath (Check only one		
of	Phys this ral dii	: To	1 Yes 2 No 27. Manner of Death	28a. Dile of Injury 28b. Time	of 28c. Injury at	Home 5 ☐ Resider 28d. Describe how	nce 6 ☐ Other (Specify) w injury occurred	-
ion	th. : After e funer	atior	Naturel 5 Pending Accident investigation	(Month, Day Year) Injury	/ Work? M 1 ☐ Yes 2 ☐ No			
Division	or Attendiater death.  Diractor: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural F State)	Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: Atter completely lilled in by the funer	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, de niner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and plac investigation, in my opinion, death occ	e, and due to the car urred at the time, da	use(s) and manner as stat te and place, and due to th	ed. ne cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	morast 710	29c. License number	29	d. Date signed (Month, Da	y Year)
			Tuo III	O VIP	778142		11-19-0	4
	D	1	30. Name and address of person who	completed cause of death (Item 23a) (Typ SNAY, MD, 1450 F	A Print) A CRCANTILE L	N.#21	7. LARGO.	20774
03	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	& Locales			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For	State of Marylan		nent of Health and	Mental Hygi	ene	
			1 - State Registrar		Certifi	cate of Death		g. No2 U U 4	38483
	Physici		1. Decedent's Name (First, Middle, Last	B Rope	<b>1</b> .		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir		4a. Pacility Name (If not institution, give	street and number)	4b.	City, Town, or Location of Dea		4c. County of Death	100011
			Oak Crest C	are Center		PARKUILLE		BHOMO	RE
ľ	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs.		Under 1 Year If Under 24 Hrs nths Days Hours Min		Year) 9. Birthp	lace (State or Foreign
	ס		Usual Residence of Decedent		<u> </u>		0-4-14	////	CACHION
	farylar ahow	ō	10a. State 10b. County		y, Town or Locatio	) i		1	0d. Inside City Limits 1 Yes 2 No
	tha N	rect	10e. Street and Number	wht	10	OF. Zip Code	10	g. Citizen of What Coun	
	th with	Funeral Director	8800 Waller	BIVO. #141	a.	21234		()SA	
	er dea Items	uner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was	Decedent of Hispanic Origin? (S , specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
980	hours after death with the Maryland ural; or ttems 23s or 28s-f show il Examirer must be nutfled at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 ∏ No If Yes, Give Year or Dates:	101	es 2 No Specify:		Specify: // )	hite
5-0036	72 ho 'natura	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Decedent's	Usual Occupation of work done during most of wo	rkina 10	6b. Kind of Business/Inc	dustry
2121	within iene. than "	du	Elementary/Secondary (0-12)	College (1-4or 5+)	Solf Ron	OT use retired)		Rulder	
	i filed I Hygid othar ent, II	Be Co	17. Father's Name (First, Middle, Last)		WIFU	18. Mother's Na	me (First, Middle, Ma	aiden Sumame)	
/lan	should ba nd Mental markad c	To B	Charles Ever	eff		Cila	Folker	+	
Maryland	and s m		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Ad	dress (Street and Number of R	ıral Route Number,	City or Town, State, Zip	Code)
_	Health Health tem 27 other tre		20a. Method of Disposition	20b. P	lace of Disposition emetery, cremator	(Name of	Date 20	Oc. Location - City or To	wn, State
OE I	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ F  '4 □ Donation 5 □ Other (Specify)	Tellioval Itolii State	ancy Valle	A		IMONIUM	MD
Baltimore,	permit. Pages Department of Important: If if any injury or c		21. Sign sure of Funeral Service Licens					5, MD 212	
	40 E 8 9		Typhberry ()	Tallelle.	EVAL	SFUNBRAL CHA	PCL 8800	HARFORD	RO.
			23a. Part1. Enter the dian se, of complishock, or heart failure. List only of Immediate Cause (Fina	ne cattle on each line.	n. Do not enter the	mode of dying, such as cardia	or respiratory arres	st,	Approximate Interval Between Onset and Death
7	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consequ		Driage			nonth
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	led Isit	niner	if any, leading to immediate cause. Enter Underlying that initiated events	Due to (or as a consequ	uence of):				
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9	entifica ding pl	Q I	IF FEMALE:	3c. If yes, outcome of pregna					
Вох	death c	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 □Ecto	pic pregnancy er (specify)		23d. Date of deliver Month	ry Day Year
P.O.	that the di ad by the detached	hysi	9 🗆 Unknown	9 Unknown	·				
	signed I		Part II. Other significant conditions con	ntributing to death but not resu	ulting in the underly	ring cause given in Part I.		cco use contribute to the	
örc	w require been si should I	eted	DIGHERI MAIL				1 Tes		ably 4 □Unknown
Vital Records,	he tay e has age 2	Completed by					24a. Was an autopsy performe	nd?   death?	sy findings available inpletion of cause of
ital		Be C	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 € ath (Check only one)	7No 1 Yes :	21 <del>/ N</del> o
of V	Physician: this certificatal director,	은	1 1 1 1 1 2 2 1 1 1 0					ce 6 Other (Specify,	
ou o	0 0 0	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	Attending Ph er death. ector: After th by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho	me, farm, street, fa		28f. Location (Street	et and Number or Rural	Route Number,
Ö	ital or rs afte ral Dir led in l	Cert	4   nomicide	building, etc. (Specify			City or Town, :	State)	1
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical	29a. Certifier Certifying Physical (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occu ion and/or investig	irred at the time, date and place ation, in my opinion, death occu	, and due to the causered at the time, date	se(s) and manner as sta a and place, and due to	ited. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License number		L Date signed (Month, D	
			1/200			053115	0	ecember 2nd	2604
	1241		30. Name and address of person who co	impleted cause of death (Item	23a) (Type, Print)	culle mo his	_	, , , , , , , , , , , , , , , , , , , ,	
	Sta	te	31. Date filed (Month, Day, Year)		ture /	porks	ω j		
	Registr		DEC 0 6 2004	32 Registrar's Signat	D A	porks			

Amend item#5, perFH, G839, 1/26/05 TT State of Maryland / Department of Health and Mental Hygiene (1) 1 - State Registrar 38484 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 30 Day 2004 Η. Roney Jr. 7:00pm <sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, O2 20) 2320 Sulgrave Ave. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 423-20-8029 XXM 2 F Year) Yrs. Director <del>-20-8029</del> Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "naturel", or Items 23s or 28a-f shov the Medical Exercit net must be notified at Director MYes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2320 Sulgrave 21209 Completed by Funeral Ave U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? ★FLYes 2 □ No H Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Administrator 6yrs jes 1 and 2 should be filed wo of Health and Mental Hygies of Health and Steam of the ritem 27 le marked other to other traumatic event, In Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Preston H. Roney Sr. Blanche Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2320 Sulgrave Ave, Baltimore, ace of Disposition (Name of Gwendolyn Roney-Wife Md 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 5 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) = 5 Department of Important: If eny injury or once. Dulaney Valley 12/6/04 Dulaney Valley, Md 21. Signature of Funeral Service Licensee Baltimore, Md. 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. March F.H. West 4300 Wabash Ave. Approximate Interval Between Onset and Death Immediate Cause (Final Frysician CHOLANGIO CARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Entart Index ing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospitel 24 hours a 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Tig Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) sursane up DECEMBER 3, 2004 D16619 Cur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD. 21236 9940 FRANKUN SQUARE DIZIVE C.VERGARA-SDARE( 31. Date filed (Month, Day, Year) . Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DEC 0 6 2004

			For State Registrar	State	of Marylan	-	artment rtificate					giene Reg. No	.004	38485
			Decedent's Name (First, Middle	Last)							2. Date of De	ath		3. Time of Death
	Physici: /Medic		Ruth D.	Rogers							Decembe	er 3	, 2004	6:15 A M
	Examin		4a. Facility Name (If not institution,	_					Location	of Death		40	. County of De	ath
ч			Mariner Health					sing		04 1/20			lontgom	
	Funeral Director		5. Social Security Number 579-05-6829	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 85	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bin (Month, Da April 1	th y Year	919 Vi	irthplace (State or Foreign Country) rginia
			Usual Residence of Decedent								APITI I	.0, 1	JIJ VI	Iginia
vlanc	мом		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
e Ma	a-fs	ctor	Maryland Montg	omery	S	ilver	Sprin	g						1 ☐ Yes 2 🎇 No
it th	or 28	Director	10e. Street and Number				10f. Zip		0.6				tizen of What (	-
ath	s 23a		1929 Hickory H					209					Lted St	
ter de	Itam	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marri	Armed F	cedent Ever in U. Forces? 2 🕅 No	.S. 13.	Nas Decedi f Yes, speci	ent of Hi ify Cubai	spanic Ori n, Mexicar	gin? (Span, Puerto	ecify Yes or No Rican, etc.)	-	Black, Wh	n <i>e</i> rican Indian, nite, etc.
ors at	, le	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, G	live Dates:		1 ☐ Y <i>e</i> s 2	No No	Specify:				Specify:	White
U Z I Z I J-0000 filed within 72 hours after death with the Maryland	Satur Scal B	ted	15. Decedent (Specify only highes		0		ient's Usual			t of worki		16b. K	(ind of Busines	s/Industry
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pe di	d d o	Be	17. Father's Name (First, Middle, L Charles Dishm	•							(First, Middle,			
should	d Me mark matic	2	19a. Informant's Name/Relationsh			19h Mailir	a Addrose	(Street a	Sar		(not av			Zin Codo)
<b>14.0</b>	Ith an 27 is r trau		Renee C. Gambor		ter									Maryland 20906
ָרָ פַּ	f Hea itam otha		20a. Method of Disposition	<u> </u>	20b. P	Place of Dispo semetery, cren	sition (Nam	e of	Ţ	0	ate		ocation - City of	
Pages	nt: If		1 ☐ Burial 2 🖾 Cremation  1 ☐ Donation 5 ☐ Other (Sp		1 51816	tgomery (				ecem 200	ber 4,	Beth	nesda.	Maryland
	Department of Health a Important: If itam 27 is any injury or other training.		21. Signature of Funeral Service L	icensee	M01	305 Rol	Name and Dert A.	Addres Pum	s of Facilit phrey	y Funer		Beth	esda–Che	vy Chase, Inc.
	46		23a. Part1. Iter the disease, or shock, or heart failure. List of	complications that	caused the death								yland 20	Approximate Interval Between
PI	ysician		Immediate Cause (Final disease or condition	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Dr. a.	```	71							Onset and Death
	Medical		resulting in death)	Due to	o (or as a conseq	uence of):								3000
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th cer	signed by the attending ph d be detached for use as th	hysician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna birth 2  Feta		Ectopic pre	manev				10	23d. Date of de	
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hat th	d by Jetach	0	Part II. Other significant condition	ns contributing to	death but not res	ulting in the u	aderlying ca	usa diva	n in Part I		23a Did to	phaceo i	usa contributa	to the cause of death?
ires t	signe d be d	1 by	Olemo	rsitu	acan bar not ros	and an area	idonying oa	.u.50 give			1 🗆 Y		~ ^	Probably 4 DUnknown
2 80 8	been si	ete									24a. Was		24h Wasa	autopsy findings available
he la	e has	Completed									autop perfo	rmed?	prior to death?	completion of cause of
	certificate rector, pag	0	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes (Check only o	al XNo	1 ☐ Ye	s activo
ysicia	this cer al direct	OB	examiner?	Hospital:	Inpatient 2	ER/Outpatien	t 3 DO	Othe	200		ne 5 ☐ Resid	-	6 □Other (Sp.	ecify)
) E	ter th	n: T	27. Manner of Death	28a. Date (Mo	of Injury oth, Day Year)	28b. Time of	28	lc. Injury Work	at		28d. Describe h			,
endir in	or: A	catle	2 ☐ Accident investig	ation			М	1 🗆 Y	′es 2 ☐ i	No				
or Att	fter d	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Plac	e of Injury - At ho ding, etc. (Specify	ome, farm, stri y)	eet, factory,	office		2	28f. Location (S City or Tow			Rural Route Number,
oital L	eral C		29a. Certifier 1 X Certifying	Physician: To th	a bast of my kno	wlodge death	L COOURA d	t the time	a data an	d place d	and due to the			
the Hospital or Attending Physician:	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		xaminer: On the	basis of examina nner stated.	tion and/or inv	estigation,	in my op	inion, deal	th occurre	ed at the time,	date and	and manner a place, and du	is stated. ie to the cause(s)
oth	o th	Me	29b. Signature and title of certifier				29c.	Licens <i>e</i>	number		:	29d. Dat	te signed (Mor	nth, Day, Year)
	<b>h</b>		1		Ems.		0	5:00	30	8		Dec	cember	3, 2004
	5		30. Name and address of person v		use of death (Item		Print)	71		-				
			Daphna Henkin,				oad,	Whea	ton,	Mary	1and 20	0902	!	
	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Signa	L	door	the s						
			DEC 0 6 20	114 /4	77,	1- 1	1	-						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 23, 2004 Physician 6:05 P M Sabrin /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Hebrew Home of Washington Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 3, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🕏 F Connecticut 86 110-48-8694 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mantal Hygiene. and it if them 23e or 28e-f show and it if them 27 is marked other than "neturel", or Items 23e or 28e-f show ury or other traumatic event, it which the Example Items the notified. 1 ☐ Yes 2 💢 No Rockville MD Montgomery Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 6121 Montrose Road USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Completed by Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nursing Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Luigi Rossi Rosa Rossi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5414 Galena Pl. NW Washington, DC 20016 Amy Sabrin - Daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov. 28, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Department of Important; If any injury or once. Metropolitan Crematory 2004 ' 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22 Name and Address of Facility eral Home lec 1570 Northern Blvd. Manhasset, New York Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTI-INFARCT DEMENTIA Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter choositying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending pt IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate ha 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of deptifier 18084 W.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MENTROSE U=1)-6121 2004 32. Registra's Signature 31. Date filed (Month, Par 19 State Registrar

R. SYBRIN

			_ For	State of Maryland / D	epartment of Health and N	Mental Hygie	ne ool	001000
			1 - State Registrar		Certificate of Death	Reg.	MUUL	38487
	Dhusisi		1. Decedent's Name (First, Middle, Last	)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		SHAQUILLE	RVAN SMI	TH-BEY	Decembe		7:41 a M
	Examin		4a. Facility Name (If not institution, give		4b. City, Town or Location of Death		4c. County of Death	
			Franklin Square	Hospital Cent	1330000	7	Baltim	ore.
	Funeral		5. Social Security Number 6. Se	14 000	rs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign intry)
	Director		217-41-0399 Usual Residence of Decedent	70		DEC. 21,1	993 MA	-RYLAND
	yland		10a. State 10b. County	10c. City, Town	or Location		1	10d. Inside City Limits
	Mar a-f st	to	MARYLAND BALT	MORE	NOTTINGHA	m		1 XYes 2 No
1	th the	)lre	10e. Street and Number		10f. Zip Code		Citizen of What Cou	ntry?
0	death with the Maryland ms 23a or 28a-f show rmust be notified at	la I	93 FERNS	WAV	2123	6	45.	A
-	ar de a	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	can Indian, etc.
15-0036	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: 13 /	1 0 4
Shaqu 21215-0036	tural	edt	15. Decedent's Edu		Decedent's Usual Occupation	166	. Kind of Business/In	ACL
ا 15	in 72 n "ne Medik	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed)	Give kind of work done during most of work life. DO NOT use retired)	ing	Killa of Basillessylli	dustry
	d with giene ir tha	EO	4 TITGRADE	College (1-4or 5+)	STUDENT		50	HOOL
	e file al Hy r othe vant,	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid		
yla	should be filed within 72 hours after death wind Mental Hygiene. marked othar than "natural", or Items 23a imatic evant, Ite Medical Examinar must b	Tof	LEE	SMITH (	JR. LUNI	V		250N
- bey	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f show any injury or othar traumatic evant, the Mudical Examinar must be notified at once.		19a. Informant's Name/Relationship (Ty		Mailing Address (Street and Number or Run	al Route Number, Cit	y or Town, State, Zip	Code)
1	and lealth m 27 har tr		LYNN SIMPSON	(MOTHER) 43		TINGHAM		1236
Smith Baltimore,	ges 1 t of H If ita or ot		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State cemetery	crematory or other place)	100	Location - City or To	own, State
mitte	t. Partmen tant: njury		`4 □Donation 5 □ Other (Specify)	ARBU	TUS CEMETERY 12-1 22. Name and Address of Ficility BA	0-04 AT		MARYLAND
∑ ∑ Bal	Depar Impor any ir		21. Signature of Funeral Service Licens	1/12/11/2019	22. Name and Address of Hoility BA	20WN JR		AL HOME
() ) —	45244		23a Part 1 Enter the disease or comple	inations that equend the death. Do no	of enter the mode of dying, such as cardiac	AVE, K	ALTO, MI	0.21217
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	of enter the mode of dying, such as cardiac	or respiratory arrest,	ĺ	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	myocardial	hypoper fusion			
	Examiner			Due to (or as a consequence of	): (3)			
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t ( r as a consequence of	):			
ot.	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
0,	an an rial-tr		resulting in death) Last	Due to (or as a consequence of	):			
68760,	ficate be executed physician and sthe burial-transit	edical						
	ng ph	Med	IF FEMALE:					
Вох	leath certifi attending I for use as	an/l	23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 DEctopic pregnancy		23d. Date of delive	*
	e dea the at ned fo	Physician/M	in the past 12 months?  1 Yes 2 No	4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month	Day Year
P.O.	res that the death certigned by the attendin be detached for use	Phy	9 Unknown					
	The law requires that the death certiinte has been signed by the attending age 2 should be detached for use a	by	Part II. Other significant conditions cor	itributing to death but not resulting in I	ne underlying cause given in Part I.		o use contribute to th	
Ö	w requir been si should	eted	CF	<u> </u>		1 Tes	2/ANO 3 Prob	pably 4 Unknown
ital Records,	e law has t	ompleted				24a. Was an autopsy	prior to cor	psy findings available mpletion of cause of
a		O				performed	death?	2 No
\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	siciar certif recto	o Be	25. Was case referred to medical examiner?	ospital:	04	(Check only one)		
1-10	Phys r this ral di	$\vdash$	27. Manner of Death	28a. Date of Injury 28b. Tir	ation 30 DOX 40 Nursing Hot	me 5 Residence 28d. Describe how in		1)
<b>√</b> 5	th. : Afte	tor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Inj		104. 5030.156 (104/11)	ury occurred	
Division	Atter r dea sctor by the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm		28f. Location (Street	and Number or Rura	I Route Number.
وَ	al or	Certification:	4 Homicide	building, etc. (Specify)		City or Town, Sta	te)	
	pspit hours unara y fille		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge,	death occurred at the time, date and place, a	and due to the cause	(s) and manner as st	ated.
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, to	edical	(Check only 2 Medical Examir one)	and manner stated.	or investigation, in my opinion, death occurr	ed at the time, date a	nd place, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	^ ^	29c. License number	29d. D	Date signed (Month, L	Day, Year)
	1.		Amy Dan	Y \	0006/6/0	Dec	ember 4	1 acra
	X		30. Name and address of person who co		(ne Print)			
			Dr. amy Sarof		n Square Drive	Baitin	nore mo	15616
	Star Registra		31. Date filed (Month, Day, Year) DEC 0 6 200	32. Registrar's Signature				
	_		V U / IIII	TENTHOLICE TO	I A A			

DHMH 17 Rev 1/2001

ORIGINAL

04-07763 RKD

			For	State of Maryland / Depart	artment of Health and M	lental Hygien	е
			State Registrar	Ce	rtificate of Death	Rag. N	9001. 201.00
	Physici	an	Decedent's Name (First, Middle, Last,	- 0 1		2. Date of Death DECEMBER D	By 20 Mear 0.500
-	/Medic		HIICE MARI	E SMOOT		DECEMBER	<b>2</b> , 20 <b>0</b> 4 9:50Р. м
7	Examir	er	<sup>4a.</sup> Facility Name ( <i>If not institution, give</i> JOHNS HOPKINS HOSP	street and number)	4b. City, Town, or Location of Death BALTIMORE	4	c. County of Death
			Social Security Number 6. S		If Under 1 Year If Under 24 Hrs.	8 Date of Birth	9. Birthplace (State or Foreign
	Funeral Director			M 2 2 F 5 2 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year	Country) CAROLINA
	P _		Usual Residence of Decedent			THIC.	03477197100771071
	show	_	10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits 1 ☐ es 2 ☐ No
	he M	ectc	10e. Street and Number	PATTI	more	10- 0	
	with with	Ö	21116 En+	Diviso St	10f. Zip Code	log. C	itizen of What Country?
	death with the Maryland ma 23a or 28a-f show rmust be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian,
9	or Ite	F	1 Never Married 2 Married	1 ☐ Yes 2√1No	If Yes, specify Cuban, Mexican, Puèrto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, etc.
215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. I Health and Mental Hygiene "natural" or Itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:			Specify: BIACK
15-	"nati	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. Dece e completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ng 16b. I	Kind of Business/Industry
212	within iene. than "	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	SE KEEDING	B	OWIEDSTATE
	illed Hygi other	BeC	17. Father's Name (First, Middle, Last)	1		(First, Middle, Maide	n Sumame)
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	To B	JAMES WAH	ER WYNN	MARY	Lauis	E KAY
ary	and h		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Mailir	ng Adress Street and Number or Rule	oute Number, City	or Town, State, Zip Code)
	of Health of Health Item 27 I	1	MICHAEL	Smoot 9017	Purdy LAnt	KESVII	1E, Md. 21208
Baltimore,	ges 1 t of H ff Itea or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F	20b. Place of Dispo cemetery, crer	natory or other place)	Pate 20c. L	ocation - City or Town, State
ţ	t. Partmen		'4 □Donation 5 □ Other (Specify)	ARDUTU:	5 Mem. [K. 12]	0/2004 H	Edutus Man
Bal	permit. Pages Department of the Important: If Ite any Injury or of any Louce.		21. Signature of Funeral Service Licens		Name and to resent Facility	MESINE	Fun me 17
		-	23a Part1. Enter the disease, or compl	cations that raused the death. Do not ent	8 1 4 N 1 D 6 Ad u	Ay DAT	To, // XL. 2/2/3
	Dhusisian		snock, or near failure. List only of	ne cause on each line.			Interval Between
7	Physician /Medical		disease or condition resulting in death)	HYPERTENSIVE ARTERION Due to (or as a consequence of):	OSCLEROTIC CARDION	ASCULAR D	LSEASE
	Examiner		Constitute for the annual cons				
	ס ∉	ner	Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):			
	ecute and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or so a consequence of):			
60,	icate be executed physician and s the burial-transit	ai E		Due to (or as a consequence of):			
68760	_ 0)	edicai		J. =			415.
Box (	death certific e attending pl d for use as f	n/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	<b>7</b>		23d. Date of delivery
	death	by Physician/M	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of death 5☐	Ectopic pregnancy Other (specify)		Month Day Year
P.0	that the ed by th detache	hys	9 🗆 Unknown	9☐ Unknown			
	S = 0	by	Part II. Other significant conditions cor	ntributing to death but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death?
ord	w requires been sign should be	ted				1 ☐ Yes 2	No 3 Probably 4 Nonknown
Records,	4 8 0	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
alF	The ate					performed?	1 Yes 2 No
of Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	Iospital: 1  Inpatient 2 ER/Outpatien	26. Place of Death		
o	ding Phys	n: To	27. Manner of Death	28a. Date of Injury 28b. Time of		8d. Describe how inju	iry occurred
ion	Attending F ir death. ector: After by the funer	ation	Natural 5 Pending investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
Division	r Atte er dez recto by th	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office	28f. Location (Street al City or Town, State	nd Number or Rural Route Number,
Ö	Itel or	Cer					
	To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	(Check only 21 Madical Examil	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause(s	) and manner as stated. d place, and due to the cause(s)
	the the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.			
В	N W W		David K 11	1/ 21/2	29c. License number O.C.M.E.	DECE	nte signed <i>(Month, Day, Year)</i> MBER 3, 2004
	\		30 Name and address of person who are	mpleted cause of death (Item 23a) (Type,	Print		
/	H			mipleted cause of death (item 23a) (Type,	111 PENN STREET	BALTIMORE.	MARYLAND 21201
	Sta	te	31. Date filed Month Do. Bar 1004	32/Registrar's Signature	porks		
V	Registr	ar			La como		

± <b>-</b> / :	30 /		Unpend Item 2	3a,pt	State 9	f Mary 28a	land / D f per	epartme ne Go Sertifica	nt of 1 te of	lealth Death	and M tas	lental Hy	giene Beg No 1	n I.	301.00
	Physicia	1	. Decedent's Name (First, M	iddle, Las				malls				2. Date of De Month	ath Day	Year	3. Time of Death
****	/Medica		Anthony a Facility Name (If not institu		street and nu	nher)	51	latis		4b. City. T	own, or Lo	NOVEMB ocation of Death			12:03p
5	Examine		ÆRCY HOSPITAI		Stroot and his	,,,,,						CITY	NA		
9	Funeral Director		Social Security Number 220–74–2322	6. Se	ex XIM 2□F	7. Age (In	yrs. last birth	day) If Und Month	er 1 Year		r 24 Hrs. Min.	8. Date of Bird (Month, Da 7-27-	th y, Year)	9. Birth	olace (State or Foreign ntry)  Md.
J	P	-	Isual Residence of Decedent					Landina							
	show	- 1	Md .	nty NA		10	c. City, Town Ra	Ltimor	2						10d. Inside City Limits 1X Yes 2 □ No
	28e-f		0e. Street end Number						ip Code				10a. Citizen of \	What Cou	ntry?
	th with the Meryle 23e or 28e-f sho ast be nothed at	5	7141 Bexhill	Rd.					212	44			U	SA	•
	ifier death with the Mer r terms 23a or 28e-f si niner must be rectified	1	1. Marital Status		12. Was Dece Armed Fo	rces?	in U,S.	13. Was Dec	edent of H ecify Cub	lispanic O an, Mexica	rigin? (Sp in, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac Blac	e - Ameri ck, White,	can Indian, etc.
Maryland 21215-0020	urs e	\$	1 XNever Married 2 N 3 Widowed 4 Divor	i	1 ☐ Yes If Yes, Giv Year or D	/e		1 ☐ Yes	2⊠ No	Specify	:		Specify	/: B]	lack
5-0	natural natural		15. Dece (Specify only hig				(	ecedent's Us Give kind of	vork done	during mo	st of work	ing	16b. Kind of B	usiness/In	dustry
121	within		Elementary/Secondary (0-1	2)	College (	I-4or 5+)		ife. DO NOT		d)			Varie	.c	
<b>d</b> 2	be filed withintel Hygiene.	3 -	11th grade 7. Father's Name (First, Midd	ile, Last)				Labor	er	18. Moth	er's Name	e (First, Middle,	Maiden Suman		
lan	1 and 2 should be filed withir Health end Mentel Hygiene. em 27 is merked other than ther traumetic event, the Meriter traumetic event, the Meriter traumetic event, the Meriter traumetic event, the Meriter traumetic event.	5	Aubrey			Sper	ncer			E	mily			Small	ls
ary	s 1 and 2 should I Health end Mer tem 27 is marke other traumatic		19a. Informant's Name/Relati	onship (7	уре, Print)		19b.	Mailing Addre	ss (Street	and Numb	er or Rur	al Route Numbe	er, City or Town,	State, Zip	Code)
	and 2 ealth n 27 i		Pamela Small	s						l Rd.	, Ba	ltimore		212	
Baltimore,	ges tot	2	Oa. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other				-	disposition (A crematory of Carmel	other plac		1	Date 2-4-04	20c. Location -		
alti	permit. Par Departmen Important: any Injury once.		21. Signature of Funeral Serv	ice Licens	S <del>00</del>	1		22. Name	and Addre	ss of Facil	ity	Balti	more, M	d. 2	21202
Ω	88 = 88	ŀ	> Glad	<b></b> _	War			Marc	F.H	. Eas	t	1101 E	. North	Ave.	
	Physician /Medical		23a. Part1. Enter the disease shock, or heart failure.	, of comp List only o	one cause on e	ach line.			ode of dyir	ng, such a	s cardiac	or respiratory a	rrest,		Approximate tnterval Between Onset and Death
	Examiner	ШЭ	disease or condition resulting in death)		Narco		ntoxic to (or as a co		n-					i i	
	7 5	2				500	10 (01 43 4 00	risoquorioo e	·/·						
	cete be executed physician end the burial-trensit		Sequentially list conditions,		D. ———	Due	to (or as a co	nsequence o	'):						
8760,	be ey	3	Sequentially list conditions, feny, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events	1	C										
687	= = =	)	resulting in death) Last			Due	to (or as a co	nsequence o	):						
Box	ettending for use e				d										
	death	F	Part II. Other significant cond	litions co	ntributing to de	ath but no	ot resulting in	he underlying	cause giv	ren in Part	l.	23b. Did 1	tobacco uae co	ntribute t	o the cause of death?
P.0	requires that the death certific		Complications	Of F	ITV Tof	octio	n/ATDS					10	Yes 2 No	3 🗆 Pro	bably 4 ZUnknown
	signed		SOMPTICALIONS.	OL I	ITA TIIT.	CCLIO	ну ктоо					Ode Wee		24h W	ere autopsy findings
Vital Records,		-											an autopsy rmed?	av	ailable prior to impletion of cause death?
Re	The law											120	Yas 2 No		⊈Yes 2□ No
ita	certificate harrector, page		25. Was case referred to med examiner?	ical		-			,05-	26. Plac	e of Deat	h (Check only o	one)		
of V	\$ 10 D	2	1 XYes 2 No		Hospital: 1 □ I	npatient	2XX€R/Outp	atient 3		4LIN			dence 6 □Oth		(y)
	D 0 0 0	<u> </u>	7. Manner of Death 1 □Natural 5 □ Per		Found	of Injury th, Day Yea	ar) 28b. Tii	ury	28c. Injur Wor		101-		now injury occur	red	
Division	Attending or death.	1		estigation uld not be ermined	11_20	$\alpha \alpha \alpha t$			office	Yes 2		Unknown	1 Street and Numb	er or Run	al Route Number.
Ο̈́	or A efter Direct	5	4 ☐ Homicide	emined	Scen	ng, etc. <i>(S</i>	pecify)	,, 51, 551, 1661	, oo		F	City or Too altimor	vn, State) MTC	,954	Forrest St.
	To the Hospital or Attending Pi within 24 hours effer death. To the Funeral Director: Affer it completely filled in by the funeral	3 1	29a. Certifier 1 ☐ Certi (Check only 2 ☑ Medi	lying Phy	aiclen: To the	hest of my	y knowledge,	deeth occurre	d at the tir	me, date a	nd place	and due to the	cause(s) and ma date and place,	inner as s	tated.
	within 24		one) X 29b. Signature and title of cer		and man	ner stated.			9c. Licens				29d. Date signe		10
•	vii vii		Due I	mer	•••			•	SC. LICOIIS	OCME	E				3, 2004
		3	0. Name and address of pers	on who o	ompleted caus	e of death			Stree	t, Ba	altim	ore, Ma	ryland :	<b>2120</b> 1	L
	State Registra		31. Date filed (Month, Day, Ye		20 0	egi frar's			100	-					
	10310114	4		V V	-001	- Cardina			-						

			1 - For State Registrar	State of Marylan	id / Depart <i>Certii</i>	ment of F	lealth and <i>Death</i>		gierze () () (;	38490
H	Physici	an	Decedent's Name (First, Middle, La	- 1.1				2. Date of Dea Month	ath Day Year	3. Time of Death
· Marie	/Medi	cal		iony, Smith				1a	9 900	MR F0:01 P
1	Examir	ner	4a. Fecility Name (If not institution, give terms Affor	ins medical Ce	softer	D. City, Town, o	r Location of Dea	ith	4c. County of De	ath
	Funeral		5. Social Security Number 6.5	Gex 7. Age (In yrs.	last birthday)	Under 1 Year	If Under 24 Hrs		h 9. Bi	rthplace (State or Foreign
	Director		215-02-3593	00 M 2 F 85	Yrs.	lonths Days	Hours Min		(Year)	Country
	pu ,		Usual Residence of Decedent	100 6	Town and a said					
	anyla show	5	10a. State 10b. County	10c. Cit	y, Town or Locati	ion				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Directo	10e. Street and Number	1018E 7	ARREY.	10f. Zip Code			10g. Citizen of What C	
	Mile of the control o	급	1 1 1 1 1	01.00					Tog. Citizen of verial C	Country
	death	Funeral	8820 WALTHER  11. Marital Status	12. Was Decedent Ever in U.	.S. 13. Was	Decedent of H	lispanic Origin? (	Specify Yes or No- rto Rican, etc.)	14. Race - Am	encan Indian,
9	after or item	Ξ	1 ☐ Never Married   Married	Armed Forces? 15€ Yes 2 No				rto Rican, etc.)		ite, etc.
93	72 hours after death with the Maryland natural', or items 23a or 28a-f show Jisal Examiner must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: \( \mathcal{V} \) \( \mathcal{V} \)	77	Yes 2¶ No	Specify:		Specify: W	FITH
21215-0036	"netu	Completed	15. Decedent's E (Specify only highest gr		(Give kind	's Usual Occup of work done	during most of we	orking	16b. Kind of Busines:	s/Industry
12	within iene. then.	щ	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired	3)		1	A 0
d 2	Hygie Hygie other ent, II		17. Father's Name (First, Middle, Last	)	2116	11/324	18. Mother's Na	me (First, Middle,	Maiden Surname)	AB
an	ld be ental ked c	To Be	HARRY	SMITH			ACILIZ		ROSTABL	Q) = Q
Maryland	2 should be and Mental is marked is umaric ev	-	19a. Informant's Name/Relationship (	_ , , , , , ,	19b. Mailing A	ddress (Street			r, City or Town, State,	Zip Code) 21234
	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.  If item 27 is marked other then "natural", or items 23a or 28a-1 show or other traumatic event, the Modical Examiner mast be notified at		Helen R. SM	HTI	18880	KTIASU	ER BLV	DAA.O	SAL SIME	CARLEAR D KE
Baltimore,	of He		20a. Method of Disposition 1 □ Burial ② □ Cremation 3 □	Removal from State	Place of Disposition	on (Name of bry or other place	(B) 1.0 (B)	Date	20c. Location - City o	r Town, State
Ĕ	permit. Pages Department of I Important: If it any injury or o		'4 Donation 5 □ Other (Special	Removal from State	335 HXS	CATEN		125	- CRISTHILL	Checkbard.
3all	permit. Pa Departmen Important: any injury once.		21. Signature of Fundral Service Lice	nikae	22. Na 2 V 6	ame and Address	S of Facility	JE WORK	ر کا	21834
_	403 6 0		23a. Part1. Enter the disease, or com shock, or heart failure. List only			DO HAR	-	4040 He	KKNITTE L	Approximate
	cate be executed XX hysician and many the burial-transit the burial-tr	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jaces or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of the consequence o	uence of): uence of):					Interval Between Onset and Death
Box 6	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4☐ Pregnant at time of de	death 3 □Ect	opic pregnancy ner (specify)	(# *)		23d. Date of de Month	livery Day Year
rds, P	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions of	contributing to death but not resu	ulting in the under	lying cause give	en in Part I.		pacco use contribute to es 2 □ No 3 □ P	o the cause of death?
l Rec	as b	Completed						24a. Was a autops perform	y prior to	utopsy findings available completion of cause of 2 No
Vit.	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	-	Otho		ath (Check only on		
<del>t</del> o	Phys this ral dir	ů.	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 M Inpatient 2 □	ER/Outpatient 3 28b. Time of	B DOA	" 4 ☐ Nursing H		ence 6 Other (Spe	ocify)
5	ding I	tion	1 ■ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work	(? Yes 2∐No	200. Describe no	ow injury occurred	
Division	or Attanding after death. Director: After in by the fune	fica	3 Suicide 6 Could not b	e 28e. Place of Injury - At ho	me, farm, street.			28f. Location (St	reet and Number or R	ural Route Number,
É	alor A s after al Direction od in by	Certification:	4  Homicide determined	building, etc. (Specify	")			City or Town	n, State)	
	To the Hospital or Attanding Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier 1	ysician: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, death occion and/or investi	curred at the tim gation, in my op	ne, date and place pinion, death occu	e, and due to the caurred at the time, da	ause(s) and manner as ate and place, and due	s stated. a to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Mont	h, Day, Year)
	1.1		Latron	mD, mD		AU4170	045H158	365	12/2/04	
	10x1			gron, mo a	2256re		Baltim	ore, MD	91301	
*	Sta Registr	100	31. Date filed (Month, Day, Yeer)  DEC 0.6 2004	32, Registrar's Signat	de de	oaks				

		ı	1 - State Amend Item 5 I	•			of Health and No. 104 tas of Death		_	04	38491
2	Physicia /Medic Examin	al	Roosevelt Swa     Swa     Fecility Name (If not institution, give str			4b. City, To	own, or Location of Death		2004 4c. County o	Yeer	3. Time of Death 8:03am
	Funeral Director	ei	Residence 6033 N.	Hill Mar (	n yrs. last birt	hday) If Under 1	rict Height: Year   If Under 24 Hrs. Days   Hours   Min.	8. Date of Birth	PG 935	Country	ce (State or Foreign ner, Alabama
	o o	tor	Usual Residence of Decedent  10a. State 10b. County  MD PG	11	Oc. City, Town	or Location	hts				I. Inside City Limits
	n with the	Funeral Director	10e. Street and Number 6033 N. Hill Mar Ci	rcle		10f. Zip C 2074			. Citizen of WI USA	hat Country	1?
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If Health and 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Madical Examinat must be nutified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	R. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Deceder If Yes, specify	nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto No Specify:	pecify Yes or No- Rican, etc.)		- American White, etc	С.
0-6121	within 72 hor ene. than "natur the Medical E	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)		Decedent's Usual (Give kind of work life. DO NOT use	done during most of work retired)	king	Ford Co		stry
	should be filed with nd Mental Hygiene. marked other that imatic event, the	To Be C	17. Father's Name (First, Middle, Last) Henry Bibbs				18. Mother's Nam Leona Ed	e (First, Middle, Me dins	iden Sumame	)	
Ĕ	1 and 2 shor Health and M tem 27 is ma		19a. Informant's Name/Relationship (Type Debra A. Mack (da	ughter)	60	033 N. Hi	Street and Number or Ru 11 Mar £irc	le Distri	ct Hei	ghts,	MD 20747
baitimore	permit. Pages 1 an Department of Heal Important: If tem 2 any injury or other 20028.		20a. Method of Disposition  ★★Burial 2 □ Cremation 3 □ Re  • 4 □ Donetion 5 □ Other (Specify)		cemeter	Disposition (Name y, crematory or other it Memori	al Park 12/		rren,M	•	
Dail	Departi Departi Importi any inji		21. Signature of Funeral Service Licensee		846	3821 1	Ados Ster Fu 4th St. NW	Washingto	n_DC 20	0011	
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. Lost only one immediate Cause (Final disease or condition resulting in death)	ations that caused the cause on each line.  Due to (or as e company)	teno	Elevition	of dying, such as cardiac	or respiratory arres	die	10	opproximate interval Between conset and Death
	e be executed /sician and e purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c							
<b>68/6</b> 0,	cate be ex physician the buria	<u>a</u>	L d.								
O. Box o	the death certificate y the attending phys ched for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	c. If yes, outcome of 1 Live birth 2   4 Pregnant at tin 9 Unknown	Fetal death	3 □Ectopic preg 5 □ Other (spec			23d. Date Mon	of delivery th D	ay Year
cords, P.	uires that the de signed by the a lid be detached f	b	Part II. Other significant conditions cont	ributing to death but i	not resulting in	the underlying cau	ise given in Part I.				cause of death?
Ř	sicien: The law requires that the certificate has been signed by thirector, page 2 should be detache	Completed						24a. Was an autopsy performe	pr pd? de	fere autops rior to comp eath? Yes 2	y findings available bletion of cause of
Vital	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:	2 □ ER/Ou	tpatient 3□ DOA	Other	th (Check only one)		* /S===+h-l	
0	b d	-	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. 1		c. Injury at Work?	28d. Describe how		, , , , , , ,	
Division	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	Certification:	1 Acident 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, fa	М	1 ☐ Yes 2 ☐ No	28f. Location (Stre City or Town,	et and Numbe State)	r or Rural F	Route Number,
_	Hospital 24 hours Funeral etely filled	Medical C			xamination an		the time, date and place in my opinion, death occu				
)	To the within To the complex	Me	29b. Signature and title of certified	<i></i>		29c.	License number	290	1. Date signed	(Month, De	iy, Year)
	1		20 Name and address of person who con	npleted cause of dea	th (Item 23a)	(Type, Print)	on RI #10	13 77.W	bohok	pu	W20144
	Sta	ate	31. Date filed (Month, Day, Year)	33. Registrar	s Signature 4	Low	1. 6		0		

			For State Registrar	State of M	arylan		artment of H rtificate of L		d Mental H	ygiene Reg. No.	)04	38492
			1. Decedent's Name (First, Middle, La	st)					2. Date of D	eath Day	Year	3. Time of Death
	Physicia /Medic			Robert	: 5	Shirri	el		Novemb	2 -	2001	9:15 PM
	Examin	-	4a. Facility Name (If not institution, given	e street and number	1		4b. City, Town, or	Location of D	eath	4c. Cou	unty of Death	1
				laris			Balto			N/	Α	
	Funeral Director		220-38-4279	Sex 7. A 1∭ M 2□ F	ge (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	lin. (Month, L	lirth Da <i>y, Year)</i> 20–1942	Cor	nplace (State or Foreign untry) Md
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City	. Town or Lo	cation					10d. Inside City Limits
	lanyla sho	ō										1 √Yes 2 No
	28a-	Director	Md N/	A	Dà	11to	10f, Zip Code			10g Citizen	of What Cou	intry?
	with Sa or	ā	215 Edgevale Ro	ad			21225			US		,
36	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Evarierer must be notified at one.	by Funeral I	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces Wayes 2 If Yes, Give Year or Dates:	?		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin?	? (Specify Yes or Nuerto Rican, etc.)	1	Race - Amer Black, White ecify: B1	
ĕ	2 hou	ted	15. Decedent's E			16a. Dece	dent's Usual Occupa	ation		16b. Kind o	of Business/I	ndustry
212	hlo 73	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or	5+)	(Give lite.	kind of work done o DO NOT use retired	during most of ()	working	State	of Ms	aryland
2	d with	No.	10th grade	N/A	.,	Ge	neral Ser	vices		State	01 116	
2	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Last	')				18. Mother's	Name (First, Middl	le, Maiden Sun	name)	
X	Ment Ment arke	ပ	Nathaniel Shirri						erine Pro			
Maryland 21215-0036	2 sh and is m raum		19a. Informant's Name/Relationship				ng Address (Street a					ip Code)
	ss 1 and 2 of Health item 27 i		Margaret Shirr 20a. Method of Disposition	iel - Wife			5 Edgeval	e Road	Balto,	_	25 on - City or T	Town State
altimore,	Pages 1 nent of H ant: If ite ary or ot		1 X Burial 2 ☐ Cremation 3		, ce	imetery, crei	natory or other place n Forest				s Mill	_
≣	it. Partmer rtmer rtant njury		* 4 ☐ Donation 5 ☐ Other (Special State of Superal Service Lice		Ga		. Name and Addres					is, riu
Ba	Depril		thme I		par		1.5000000000000000000000000000000000000	ates es o	March F, Avenue Ba			5
		1	23a. Part1. Inter the disease, or con	plications that cause	d the death						u 2121	Approximate
	Obveision		shock, or heart failure. List only Immediate Cause (Final	one cause on each	ine.	0 4						Interval Between Onset and Death
	Physician /Medical-		disease or condition resulting in death)	a Due to (or a	Y CV	1911	nee				-	<del></del>
	Examiner			0	ncirco	•	Concer					
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as		ence of):	Charles Con					
	cuted	Examin	Cause (Disease or injury that initiated events	C								
o,	an ar	EX	resulting in death) Last	Due to (or a	a consequ	ence of):						
8760,	rcate be executed physician and s the burial-transit	dicai		d					·			
9	artifica ing pl	Med	IF FEMALE:									
.O. Box	The law requires that the death certifinate has been signed by the attending to age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3[	Ectopic pregnancy Other (specify)			23d.	Date of deliv Month	very Day Year
رپ ص	es tha igned be det	by P	Part II. Other significant conditions	contributing to death	but not resu	lting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?
ğ	w require been sig should b	ed	, -,-,-,-						_ 10	Yes 2 No	o 3 Pro	bably 4 Unknown
Records,	sician: The law requ certificate has been irector, page 2 shoul	Completed							per	opsy formed2	prior to co death?	opsy findings available ompletion of cause of
Viital		Be C	25. Was case referred to medical					26 Place of	1 ☐ Yes Death (Check only		1 🗆 Yes	2   NO
<u>=</u>	yslcii is cer direct	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	ent 2 1	ER/Outpatier	it 3 DOA Othe	ar	g Home 5 ☐ Re		Other (Speci	W Lasaire
0	ding Phys	n: T	27. Manner of Death	28a. Date of Inj (Month, D	ury av Year)	28b. Time of	28c. Injury Work	/ at		how injury oc		· Nospice
Ö	ath. or: Af	atic	2 Accident investigation	n	,,	,,		Yes 2 □ No				
Division of	l or Attendate death Director:	Certification:	3 Suicide 6 Could not I 4 Homicide determined	200. Flace Of It	jury - At ho tc. (Specify	me, farm, str	eet, factory, office		28f. Location City or T	(Street and Nu	imber or Rur	al Route Number,
	Ital o								4			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerat Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exa	hysician: To the bes miner: On the basis and manner s	of examinat	vledge, deatl ion and/or in	n occurred at the tim vestigation, in my op	ne, date and pl pinion, death o	ace, and due to the ccurred at the time	e cause(s) and a, date and plac	manner as s se, and due f	stated. to the cause(s)
	To ti withi To ti	Σ	29b. Signature and title of certifier				29c. License	e number		29d. Date sig	1	
)	1, 1		> M Im	9-			SHO	354		11	132124	21
	KX		30. Name and address of person who	_		23а) (Туре,	Print)					
	J.	-		berg 30		1 Pai	SIPLE	Ciltim	iore m	d: 2	1202	)
9.5	Sta Registi		31. Date filed (Month, Dáy, Year)		rar's Signal	ure	1 .					
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DHMH 17 Rev 1/2001

ORIGINAL

		Į.	, roi	partment of Health and N ertificate of Death	Mental Hygier	0001	381.03
			Decedent's Name (First, Middle, Last)	oranoato or boat.	2. Date of Death	16" O O 14	3. Time of Death
	Physicia /Medic		Eleanor Louise Shanahan		December 1	Pay Year 4 2004	11:30A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Bayview Medical Center	Baltimore		n/a	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min	8. Date of Birth (Month, Day, Ye		nplace (State or Foreign untry)
ı.	Director		21 3 - 30 - 25 51 72 Yrs  Usual Residence of Decedent		Dec. 20,	1931   Mai	ryland
	death with the Maryland ms 23a or 28a-f show		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	a-1 s	Funeral Director	MD Baltimore Baltim	ore			1 ☐ Yes 2 ☐ XNo
	ith the	Oire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cor	untry?
	ath w 8 23a	rai	2911 Chenoak Ave.	21 234		U.S.A	
	ltems	nue	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☑ Norried  1 □ Yes 2 ☑ Norried	<ol><li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li></ol>	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
ဦ	urs af	by F	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	White
3-003e	2 hou			cedent's Usual Occupation ive kind of work done during most of work	16b.	. Kind of Business/I	ndustry
N	ithin 7 ie. ien "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)	ung		
V	ygien ygien ner th	Con		lueprint Operator		Coppers Co	J
and	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or tiems 28a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.	Be	17. Father's Name (First, Middle, Last)  Bernard V. Shanahan		e (First, Middle, Maid	len Sumame)	
Š	hould d Mer marke matic	2		ANNA L. ailing Address (Street and Number or Rui	ivingston	hung Tourn State 7	in Cadal
20	d 2 sl th an traus			'O2 Harford Road, G			
ē,	tem ?		20a Method of Disposition 20b. Place of Dis			Location - City or T	Fown, State
aitimor	Pages ent of nt: If I		1 DiBurial 2 Cremation 3 Chemoval from State		7/2004	Hydes, Ma	arvland
	mit. I partm sortal / inju		21. Signature of Europeral Service Licenspe	22. Name and Address of Facility R			
ă	Departimbor sany irr		Stephen Costs	r 1050 York Road,	Towson, M	aryland	21 204
		0.0	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician	A	1				Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	ranial Hemor	0		
	Lammer	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	· ·			11 days
	red Isit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				•
	be executed ician and burial-transil	Examin	that initiated events c. Due to (or as a consequence of):				
8/e0	cate be executed physician and the burial-transit	dical	L <sub>d</sub>				
ã	tificate ig physi as the l	ledi					
Z O Z	w requires that the death certifu been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of deliv	
	ed fo	sicie	1 Yes 2 No	5 Other (specify)		Month	Day Year
т Э	that the ed by the detache	Phy	3 Olikiowii		222 Did tobase		45
Š	signer	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	1 ☐ Yes		the cause of death?
0	law requires as been sign 2 should be	etec					
Hecords	2 8 8	ompleted			24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
VII	sician: The law certificate has b irector, page 2 s	e Co	25. Was case referred to medical	00.00	1 ☐ Yes 🎉		2□ No
	Physician: this certific ral director,	o B	examiner?	Other	h (Check only one) ome 5 Residence	6 □Other (Spec	(h)
0	ding Phys	-	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how in		ny)
JIVISION	Attending r death. sctor: Afte by the fune	ertification:	2 Accident investigation	M 1 Yes 2 No			
<u>≥</u>	r Atte	tific	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Run ate)	ral Route Number,
2	iltal o irs aft ral Di lled ir	O					
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	eath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	thin 2 thin 2 on the	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month,	Day Year)
	⊢≯≓ŏ						
	K		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)		12/3/0	, [
	10		Ali Bari Bazview M	PES-000 edical Center B Sports	, Bal	Fimore	Maryland
	Sta	te	31. Date filed (Month, Day Year) 6 2004 32 Register's Signature	& South			0
	Registr	ar	DEO 0 0 400T	1			

			State of Maryland / Department of Health and N  State of Maryland / Department of Health and N  Certificate of Death	- '	giene	04	384	95
	Physici	an	1. Decedent's Name (First, Middle, Last) Howard L. Stroterhoff	2. Date of Dea Month Novembe		2004	3. Time of	Death Рм
	/Medio		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	Novembe		ty of Death	7:55	PW
			Hospice of Baltimore Gilchrist Ctr. Towson			imore		
	Funeral Director		5. Social Security Number 217-16-4837    Social Security Number 1 Security Number 2 F    83	Jan 25,	1921	9. Birthp Coun Mary I	lace (State or and	Foreign
,	ryland how		10a. State 10b. County 10c. City, Town or Location	<del></del>		1	0d. Inside Cit	
DE LA	he Ma 28e-f s	ector	MD Not Applicable Baltimore		40- 011		1 <b>≹</b> Yes	2 No
1,55 PM	3a or 2	I Dir	10e. Street and Number 11-C Hamill Road 21210		10g. Citizen of USA	What Coun	try?	
	within 72 hours after death with the Maryland iene. iene. "Ithen" natural", or items 23e or 28e-f show the Madical Examinar must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Sive If Yes, specify Cuban, Mexican, Puerto If Yes, Give In Yes, Sive In Yes, Sive In Yes, Specify:  1 Yes, Sive In Yes, Specify:  1 Yes, Specify:  1 Yes, Specify:  1 Yes, Specify:  1 Yes, Specify:  1 Yes, Specify:  1 Yes, Specify:	ecify Yes or No- Rican, etc.)		ace - Americ ack, White, ify: whit	etc.	
5-00	72 hou	eted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ina	16b. Kind of	Business/Ind	dustry	
) 200 ℃ 21215-0036	within ene. then "	Jdmc	Elementary/Secondary (0-12)  12  College (1-4or 5+)  Research Chemist		U.S. Go Edgewoo			
30)	othe	Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle,	Maiden Suma			
(') <u>a</u>	0 6 8 0	10	William Stroterhoff Florence			- Ct-t- 7:-	0-4-1	
Mary	nd 2 salth ar 27 is r trau		19a. Informant's Name/Relationship (Type, Print)  Margaret K. Stroterhoff / wife  11-C Hamill Road; Balt		·		Code)	
ovembaltimore.	\$ = = 0		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location	- City or To		
Limor	permit. Page Department of Important: If any injury or		12/6/ 21. Signature of Fullerat Service Licepsae  22. Name and Address of Facility	704	Parkvi			
9 ea	Depa Impo any ir		Ruck Towson Funeral	Home		York	Road 21204	
-			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one pause on each line.	or respiratory ar	rest,		Approximate Interval Betw Onset and D	veen
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  A C O O C CAYCON O	notos	513		yea	
	Examiner						· ·	
+4-	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
(	s be executed sicien and burial-transit		that initiated events ' c.  resulting in death) Last  Due to (or as a consequence of):			-		
68760.	icate be physici	dlcal	d					
0 ×	eath certific attending p	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. D	ate of delive	ry	
.A A. O. B.	it the death by the atte	Physician/Med	in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  1 ☐ Yes 2 ☐ No  9 ☐ Unknown		M	onth	Day Y	ear
م م	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use cor	ntribute to th	e cause of de	ath?
工	v requires been sign should be	ted by		1 🗀 Y	es 2 No	3 🗆 Prob	ably 4 ⊡Ur	nknown
F. F. Becco	The fav ate has page 2	Completed		24a. Was a autop: perfor 1 Yes	SV	prior to con death?	osy findings an appletion of ca	vailable use of
S/Vita	icien: certific	Be	25. Was case referred to medical examiner?  Hospital: 1 Descript 2 FR/Outsatient 3 Dog Other.  Hospital: 1 Descript 2 FR/Outsatient 3 Dog Other.		10.00			
2 0	g Phys er this ieral di	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28b. Injury at Wilson 28b. Time of 28b. Injury at Wilson 28b. Time of 2b. Time of 2b.	me 5 Resid		her <i>(Specify</i> rred	Hosp:	ice
ton	9 6 0 5	catlo	2 Accident investigation M 1 Yes 2 No					
1	Direction	Certification;	4 Homicide  4 Homicide  4 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Num n, State)	ber or Rura	Route Numb	er.
4)	Hospitel or 24 hours after Funerel Director interest or inter	Medical C	29a. Certifier  (Check only one)  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the cred at the time, d	ause(s) and m late and place	nanner as st , and due to	ated. the cause(s)	
	To the P within 24 To the F	Me	29b. Signature and title of certifier 29c. License number	2	29d. Date sign	ed (Month, L	Day, Year)	
			20 Name and Report the completed against the flow 230 To 2001		Nece	nles	21/2	4004
	10+1		30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)  6601 N. Charles St:	reet H	Baltimo	re, M	<b>).</b> 21:	204
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 0 6 2004  32. Registrar's Signature  Light Li					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryl		artment of Health and rtificate of Death		ette en e	001
	Physici /Medic		Decedent's Name (First, Middle, Las	ELIZABET	-	SCHIKNER	2. Date of Death Month 12 -	9- No. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	6:00 A.M
	Examir		4a. Facility Name (If not institution, give STELLA MARIS	street and number) HOSPICE		4b. City, Town, or Location of De TIMONIUM	eath	4c. County of Death	
	Funeral Director			7. Age (In ☐ M XXF 8	yrs. last birthday) 8 Yrs.	If Under 1 Year If Under 24 H Months Days Hours M	8. Date of Birth (Month, Day, 02-02-19	rear) Cou	place (State or Foreigr intry) RYLAND
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD. BALTIN		. City, Town or Lo	TIMONIUM			10d. Inside City Limits 1 ☐ Yes 2XXIVo
	h with the 23e or 28s	al Director	10e. Street and Number 2300 DULANEY V/	ALLEY ROAD		10f. Zip Code 21093	10	g. Citizen of What Cou	•
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23e or 28a-f show other traumetic event, the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married  XX Widowed 4 ☐ Divorced	12. Was Decedent Ever if Armed Forces?  1  Yes 2 XX0 of Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes <b>2</b> XXNo <i>Specify:</i>	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White Specify:	
21215-0036	d within 72 ho giene. In then "natur Ins Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 8 YEARS		(Give	dent's Usual Occupation kind of work done during most of to DO NOT use retired) HOUSEWIFE	working 1	6b. Kind of Business/Ir	
Maryland	uld be filed fental Hygie rked other tic event, the	To Be C	17. Father's Name (First, Middle, Last) EDGA	AR T. LII	NDER		Name (First, Middle, M. IZABETH	aiden Sumame) KREINER	
Mary	nd 2 shoulth and N 27 Is mai		19a. Informant's Name/Relationship (TEDGAR T. GARVEY, SF		19b. Mailir 1431	ng Address (Street and Number or CROFTON PARKWAY	Rural Route Number, CROFTON,	City or Town, State, Zij	21114
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 eny injury or other tr. once.		20a. Method of Disposition  XXBurial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from State		natory or other place)	Date 20 -07-2004 T	Oc. Location - City or T	
Balt	permit. Depart Import eny inj		21. Signature of Funeral Service Licens  P. W. Lutton  23a. Part1. Enter the disease, or comp		R	Name and Address of Facility UCK TOWSON FUNER	_	C. TOWSON	ORK ROAD ,MD.21204
,8760,	cate be executed /Medical Examiner bhysician and the burial-transit the burial-transit	dical Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I was been successed in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Sequence of)	ensported selvosis	2/ 10/	Kefgs sis	Interval Between Onset and Death
.O. Box 68	death certifi e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)	•	23d. Date of deliver	ery Day Year
s, P	es gn be	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause given in Part I.		cco use contribute to the	
Vital Record	9 4 6	Completed	Phose oster	1 softre	<i>-</i> 2		24a. Was an autopsy performe	24b. Were auto	psy findings available mpletion of cause of
Division of Vita	Physicien: rthis certific ral director,	Certification; To Be (	25. Was case referred to medical examiner?  1 Yes 2 60  27. Manner of Death 1 Atural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year		28c. Injury at Work?  M 1 Yes 2 No	Heath (Check only one) Home 5 Residence 28d. Describe how	ce 6 Other (Specifinjury occurred	y)
Σ	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: Attencompletely filled in by the fune		4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	9cify)		City or Town,		
	To the Hospitel within 24 hours a To the Funerel I completely filled	ledical	one) 2 Medical Exami	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death unation and/or inv	occurred at the time, date and pla restigation, in my opinion, death oc	ce, and due to the cau curred at the time, date	se(s) and manner as s e and place, and due to	tated. the cause(s)
)	To with conf	Σ	29b. Signature and title of continue	11 2	>	29c. License number		Date signed (Month,	•
	6	C E S	30. Name and address of person who concept to the second s			Print) Y VALLEY ROAD	TIMONIUM	MD 2109	3
	Sta Registr	te ar	31. Date filed (Month, Pay Year) DEC 0 6	32. Registrar's Si	gnature	4 look			

6:20 A.M.

2004

DECEMBER 03,

SCHIKNER, ELIZABETH

			For Amend Item	m 2 State of Maryla	nd / Den 38,1270	artment of H 2/04dhb rtfricate of I	lealth and l Death	Mental Hygi	ene 004	38497		
	Physicia	an.	Decedent's Name (First, Middle,)	Last)			-		12/01/200	3. Time of Death		
	/Medic		Kaymond	7. lubma	n	4. 03. T.	Land of Day	Dec .	2, 2001	+ 8 IM		
	Examin	er	4a. Facility Name (If not institution, of	11.0		4b. City, Town, or	nove	n	4c. County of Dea	th		
	Funeral			Sex 7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bin	thplace (State or Foreign		
	Director		213-30-4536	15FM 20F 69	Yrs.	Months Days	Hours Min.	4-19-1	1935 4	aryland		
	land		Usuat Residence of Decedent  10a. State 10b. County	/ 10c. C	ity, Town or Lo	ocation				10d. Inside City Limits		
	Mary e-f sh	tor	Md. W/	4 R	altim	Ore				1 ∰Yes 2 No		
	th the	Director	10e. Street and Number	,		10f. Zip Code		10	g. Citizen of What Co	puntry?		
	ath wi	rai	4202 Mai	12. Was Decedent Ever in U	10 10	2/2		nasity Van as Na	U.S.A	d salas Indias		
10	fter de	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 XYes 2 No	0.5.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	14. Race - Ame Black, Whit	e, etc.		
93	within 72 hours after death with the Maryland ene. Itan "natural", or items 23a or 28e-f show Ita Medical Ezatta ner must be rediffed at	d by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯 No	Specify:		Specify:	lack		
5-	"natu	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wor	rking	6b. Kind of Business	Industry		
12	iene. iene. r then	ошо	Elementary/Secondary (0-12)	Cottege (1-4or 5+)		lustrial	Mecha	anic .	steel			
Maryland 21215-0036	al Hygi d other	Be C	17. Father's Name (First, Middle, La				18. Mother's Nan	ne (First, Middle, Mi				
yla	2 should be and Mental I is marked o	L 2	/ 11.	per			Magde	• •	dwards			
Mai	id 2 st ith and 27 is n traun	Y I	19a. Informant's Name/Relationship Mark Tubman		491	9 Pour 1		7180, Will	City or Town, State, 2	Zip Code)		
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene if the state of the st		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place			Oc. Location - City or	Town, State		
<u><u>E</u></u>	Pages ment of 1 ant: If its ury or o		1 X Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	Cify) Care	amison	Forest Vet	Con Dec	, 9, 2004	Belto, by	1.21207		
Baltimore,	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Lie		22	Name and Address	is of Pacility la	& Fyrera	lesenice	P.A.		
	the death certificate be executed with the attending physician and model for use as the burial-transit and model for use and model		23a. Part1. Enter the disease, or or shock, or heert faiture. List or	omplications that caused the dea	ath. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between		
		Immediate Cause (Final disease or condition resulting in death)  a. Candio pulmo nor y area to the condition of the condition								Onset and Death		
			rosaning in dodain,	Due to (or as a conse	quence ot):	rellitus						
		iner	Sequentially list conditions, if any, leading to infiltediate cause. Enter Underlying Cause (Disease or injury	D. ————————————————————————————————————	b. Due to (or as a consequence or):							
		Exami	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or an a conse	c. Due to (or as a consequence of):							
8760,		ai E	, , , , , , , , , , , , , , , , , , , ,	Due to (or as a conse								
9		ledicai		0				-				
Вох		an/M	F FEMALE:  23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pr				pregnancy			23d. Date of delivery  Month Day Year		
O. E.	the at	Physician/Me	1 Yes 2 No	4☐Pregnant at time of 9☐ Unknown	death 5[	Other (specify)		<del>- •</del>	MOITH	Day 16a1		
Δ	s that the dense the bod by the detached	by Phy	Part II. Other significant condition	s contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?		
ırds	w requires been sign should be	ed b	Renai	transplant				1 🗆 Yes	2 🗹 No 3 🗆 Pr	obably 4 Unknown		
ecc	2 2 2	Completed	Rhenns	stoid aut	nh3			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of		
aiR								-		2 □ No		
Ϋ́	rsician: s certifica director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatier	nt 3 DOA Othe		ome 5 Residen	ce 6 ☐Other (Spec	rify)		
n of	Attending Physician: r death. ector: After this certifici by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		at	28d. Describe how		,,,		
siol	tendir leath. tor: Af the fu	catic	2 Accident investigat 3 Suicide 6 Could no	t be			res 2 □No	001 1				
Division of Vital Records,	i gite	Certification:	4 Homicide determine		nome, tarm, sti ily)	reet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
_	Hospite 4 hours Funere ely fille	Medical C		Physician: To the best of my kn caminer: On the basis of examin and manner stated.								
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	and married dialog.		29c. License	number	290	I. Date signed (Monti	n, Day, Year)		
	1		Jamas	Mikdusini	00	D00	38046		12/2/0	4		
į	<del>tt</del>		30. Name and address of person wh	10 1 0 1	m 23a) (Type,	Print)	MD 2	1201 10	mola	1 ikdokhi		
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Sign	pature a	Bar.	7.00	70	unul IV	11100011		
	Registr		DEC 0 6 2004	Server &	40	ach						

				e or Print in Blac			-	_	
			FOI	tate of Maryland /			lental Hygie	ne 2001	20100
			State Registrar		Certificate	of Death		NOW UU4	30490
160	Physici	an	Decedent's Name (First, Middle, Last)		1 . 1	_	2. Date of Death Month	Day Year	3. Time of Death
	/Medic		FRANCIS	P. IR	umbeta		Dec.	1 200	1. 9001.
	Examin	er	4a. Facility Name (If not institution, give stree	. 1 / 1 /	4b. City, Tow	m, or Location of Death		4c. County of Deat	
- 2				idge Ka.		ear If Under 24 Hrs.	Dotte of Birth	Har 701	CI.
	Funeral		5. Social Security Number 6. Sex	7. Age (În yrs. last t		ays Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birti	holace (State or Foreign
ブ	Director		Usual Residence of Decedent	09			11-00-0	35 1/2/1	nzyrvania.
25	iand bw		10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
-6-	Mary	jo	MN Harfare	0	Forest	Hill			1 ☐ Yes 2 ☐ No
ロス	ith the Marylan or 28e-f show	rec	10e. Street and Number		10f. Zip Co	de	10g	. Citizen of What Co	untry?
3.	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or Items 23a or 28e-f show int, tra Medical Evaluine Child by Italied	Funeral Director	230 Prinum &	Ridge Rd.		31050		USA	
30	after death w or Items 23e	nera	11 Marital Status 1 12.1	Was Decement Ever in U.S. Amped Forces?	13. Was Decedent	of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White	
ي ع	after or ite	F	1 Never Married 2 Married	1 ∏Yes 2 □ No If Yes, Give	1 □ Yes 2 □	4	,	Specify: / , \	6.16
21215-0036	iral',	d by	3 Widowed 4 Divorced	Year or Dates:	/			1 01	1116
UNDE	72 hour "natural"	Completed	15. Decedent's Education (Specify only highest grade control of th	on mpleted)	a. Decedent's Usual O (Give kind of work d life. DO NOT use re	one during most of work	ing 16	b. Kind of Business/	Industry
7 121	within ne. hen	дш	Elementary/Secondary (0-12)	College (1-4or 5+)	W 10 +	140	(	Interior 1	
	filed v Hygie sthar t	ပိ	17. Father's Name (First, Middle, Last)		rear a	18. Mother's Name	e (First, Middle, Ma	iden Sumame)	*
ano d	ould be f Mental H warked of	Be				UNKN			
イトレ Maryland	should and Men s marke umatic	2	UNKNOWN  19a. Informant's Name/Relationship (Type,	Print) 19	b. Mailing Address (St	reet and Number or Rura		city or Town, State, 2	Zip Code)
Ma	01 (0 00 (0		Elizaholh Tou	mhotas	131 Prin	um Pirko	Rd From	est Hill	MD 21050
၈ ရှိ	1 and 2 Health tam 27	_	20a. Method of Disposition		of Disposition (Name o	of [	Date 20	c. Location - City or	Town, State
7 0	o 0 = =		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	oval from State	ery, cremetory er other	(IC)	2-04 F	Grest Hi	II mo
ancis Baltimore,	E 6 3		21. Signature of Funeral Service Licensee	1	22. Name and A	ddress of Facility 2			REST HILL,
ූ <b>ස</b>	permit. Depart Import any inj		vikin lineline	2 AND	EMAIST	FUNERACU			m 0 21050
IL I	100		23a. Part 1. Enter the disease, or complication	ons that pure the death. D	not enter the mode of	dying, such as cardiac	or respiratory arrest		Approximate
	14154		shock, or heart failure. List only one commediate Cause (Final		0000		2111		Interval Between Onset and Death
	Physician /Medical	3	disease or condition resulting in death)	Due to (or as a consequence		S LEUKE	NC/A		3 WEEKS
	Examiner			500 10 (0. 00 0 00.000	<b>3</b> 3.7.				
	ar Gregoria	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	e of):				
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Ċ	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a consequence	e of):				
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687	leath certificate I attending physi I for use as the b	Physician/Medic	NE SENALE					Ţ	
Вох	th cer endir r use	an/	23b. was decedent pregnant	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3 Ectopic pregr	nancy		23d. Date of del Month	livery Day Year
Ø	ed fo	sicia	1 □ Yes 2 □ No	4☐Pregnant at time of death 9☐ Unknown	5 Other (specif	5)		14101181	Day
60	at the by the	h.	9 Unknown				an Didasha	1	the cause of death?
	res that the de signed by the a I be detached I	by	Part II. Other significant conditions contrib	uting to death but not resulting	in the underlying caus	e given in Part I.			robably 4 Dinknown
ord	w require been sig should b	ted	MAPERIEVSION				1 105		
Ö	e law r has be ge 2 sh	pie	DIABETES				24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
<u>~</u>	The ate h	Completed					performe 1 ☐ Yes 2 ☐		2 No
ita i	cian: entific ector,	Be (	25. Was case referred to medical examiner?	- 13 - 14			h (Check only one)		
<u> </u>	hysia this c	2	1 Yes 2 No Hosp	1   Inpatient 2   EHV				oe 6 □Other (Spe	cify)
2	ing P	on:	I Gratulal 5 1 origing	28a. Date of Injury (Month, Day Year) 28b	Time of 28c.	Injury at Work?	28d. Describe how	injury occurred	
Sio	tand leath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home,		1 Yes 2 No	28f Location (Street	et and Number or Ru	ural Route Number
Division of Vital Becords.	or Al	Certification:	4 Homicide determined	building, etc. (Specify)	rassii, street, lactory, or	ilica i	City or Town,		na. House Hamber,
_	pital		29a. Certifier 1 Certifying Physicia	an: To the best of my knowled	de, death occurred at t	he time, date and place,	and due to the caus	se(s) and manner as	s stated.
	a Hos 24 h a Fun etely	edical	(Check only 2 Medical Exeminer: one)	On the basis of examination and manner stated.	and/or investigation, in	my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
	To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death.  To the Funaral Diractor: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Me	29b. Signature and title of certifier	723	1.78	icense number	290	. Date signed (Mont	h, Day, Year)
			Mahhran	year ALL	13	42094	X	CEMBER 2	2004
	MY		30. Name and address of person with comp	- /	a) (Type, Print)				
	10			1	ORTH AV	ENUE BE	I AR	MD 2	1014
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	/				
	Regist	rar	DEC 0 6 2004	Denne D	donto	1			

			1 - For State Registrar	State of Marylar	nd / Depa			lental Hygi	9					
	Dhyaia	ion	1. Decedent's Name (First, Middle, Las	st)				2. Date of Deati	1	3. Time of Death				
	Physic /Medi		Mary E. Tasker					December	2, 200	12:45 A M				
	Exami	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County o	f Death				
			Shady Grove Adven		Rockvil			Montg	omery					
L	Funeral Director		5. Social Security Number 6. Se 578-34-5042	ex	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, March 10	Year) 1929	<ol> <li>Birthplace (State or Foreign Country) Kentucky</li> </ol>				
	pur &		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	eation								
	e Maryla ta-f shov	ctor	Maryland Montgome		rmantov					10d. Inside City Limits 1 ☑ Yes 2 ☐ No				
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23a or 28a-f show uther, the Modical Evarrinar must be notified at	by Funeral Director	10e. Street and Number 20032 Frederick R	oad		10f. Zip Code 208	374		g. Citizen of Wh United	*				
	deat	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-		- American Indian,				
920	urs after al', or Its	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	1 ⊡Yes, speciny Cub 1 ⊡Yes 2 🖾 No		Hican, etc.)	Specify:	White, etc. White				
21215-0036	in 72 ho	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Deced	dent's Usual Occu kind of work done DO NOT use retire	pation during most of work	ing 1	6b. Kind of Busi	iness/Industry				
712	with liene	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen		,		Own Hom	e				
Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evantmer must be notified at ance.	To Be C	17. Father's Name (First, Middle, Last) James Oliver Sloa	n			18. Mother's Name Kelsey		aiden Surname)	)				
Mary	nd 2 shoulth and N 27 Is ma		19a. Informant's Name/Relationship (7 Tabitha L. Wyatt/				tand Number or Run							
ē	Head Head item		20a. Method of Disposition	20b. P		sition (Name of natory or other pla	(00)	Date 2		ity or Town, State				
5	Pages nent of I int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐:  14 ☐ Donation 5 ☐ Other (Specify	nemoval nom State		Cemeter	Dece		ooriahu	rg, Virginia				
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licens		22	. Name and Addre		ert A. P	umphrev	Funeral Home/				
	rnysician	8	23a. Part 1. Enter the disease, or compinock, of heart failure. List only of immediate Cause (kina) disease or condition	plications that caused the death	n. Do not ente	er the mode of dyi	ing, such as cardiac o	or respiratory arres	50-2005 st,	Approximate Interval Between Onset and Death				
	/Medical Examiner		Due to (or as a consequence of):											
6 =	p ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•	Due to (or as a consequence of):  CHRONIC OBSTRUCTIVE PULMONAR									
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical Examiner	Cause (Disease or Injury that initiated seents resulting in death) Last	c. CHRO  Due to (or as a consequence)		OBSTRU	OCTIVE 1	Olprox	okay l	)/SEAY5				
9	ertifica ding ph	Med	IF FEMALE:	00-16										
.О. Вох	at the death certific by the attending p	Completed by Physician/Medical	by	nyslcian	nyslcian	nyslcian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	у		23d. Date of Month	
Records, P.	quires that n signed build be det			Part II. Other significant conditions co	ntributing to death but not resu	ulting in the un	derlying cause giv	ven in Part I.	23e. Did toba		ute to the cause of death?			
eco	e law requir has been si je 2 should l							24a. Was an autopsy	24b. We	re autopsy findings available or to completion of cause of				
E 23		Con						performe	ad? dea					
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		045	26. Place of Death							
of	Phys this al dir	2	1 Yes 2 No	28a. Date of Injury	ER/Outpatient	3□ DOA Oth	1er: 4 ☐ Nursing Hor	ne 5 Residen	ce 6 □Other	(Specify)				
On	nding P ith. : After s funera	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1 □	rk?  Yes 2 □ No	28d. Describe how injury occurred						
Division	al or Attending Physician: s after death. I Director: After this certific, id in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	To the Hospital of within 24 hours all to the Funeral D completely filled in	Medical (	29a. Certifier (Check only one) Certifying Phy	sician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tir estigation, in my o	me, date and place, a ppinion, death occurre	and due to the cau and at the time, date	se(s) and manne and place, and	er as stated. I due to the cause(s)				
	To t withi To tl	Σ	29b. Signature and title of certifier	0	-	29c. Licens				Month, Day, Year)				
			n		m/20, mo DO057/24 12/2/04									
	20		30. Name and address of person who con Truong Bao, $M.D.$ ,				ce, German	ntown, Ma	ıryland	20874				
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 6 2004	32. Registrar's Signat	ura,	portal								

			For Stata Registrar	State of	Marylan	•	irtment of H		d Mental Hy	giene Reg. No.	004	38500							
Decedent's Name (First, Middle, Last)										2. Date of Death 3.									
	Physici		Linster Duma			Month	2 LDay		12:50 PM										
н	/Medic Examin		4a. Facility Name (If not institution, give streetand number)  4b. City, Town, or Location of							4c. 0	County of Death								
Н	Examin	CI	Charlestown Reti			ity	Catons	ville			Baltime	ore							
	Funeral		Social Security Number 6. Se		Age (In yrs.		If Under 1 Year	If Under 24		th Year	9. Birth	place (State or Foreign							
	Director		240-14-3589	ØM 2□F	85	Yrs.	Months Days	Hours	Min. (Month, Da	1919	Nor	my) th Carolina							
			Usual Residence of Decedent																
	nylan how		10a. State 10b. County		10c. City	, Town or Lo						Od. Inside City Limits							
	e Ma	cto	MD Baltimo	re		Cato	nsville					1 □ Yes 2√ No							
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	. Citizen of What Country?								
	23a		719 Maiden Choice	Lane	HR421			21228			USA								
	ems	Funerai	11. Marital Status	12. Was Deced	lent Ever in U. ces?	S. 13. \	Vas Decedent of Hi Yes, specify Cuba	spanic Origin n, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	)- 1·	<ol> <li>Race - America</li> <li>Black, White,</li> </ol>								
9	or it	F.	1 ☐ Never Married 2 ☐ Married	1 Yes 2	_	,_	☐ Yes 2X No	Specify:			Specify: whi	te							
21215-0036	be illed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or ttems 23a or 28e-f show ovent, the Medicul Evarulinar moral by rediffed at event, the Medicul Evarulinar moral by rediffed at	d by	3 Widowed 4 Divorced	Year or Da	tes: <b>'</b> 42-					105 16:-	d of D	d							
Ϋ́	"nat	Completed	15. Decedent's Edi (Specify only highest grad			(Give	lent's Usual Occupa kind of work done o DO NOT use retired	luring most of	f working	I DD. KIN	d of Business/In	dustry							
12	withir sne. Ithan	ш	Elementary/Secondary (0-12)	College (1-			signer	,			display								
2	e filed within al Hygiene. i other than " vent, the Me		17. Father's Name (First, Middle, Last)		•	u e	Signer	18. Mother's	Name (First, Middle										
and	otal Ped o	Be	Linster Toler Sr					Mag	ggie Canad	v	,								
Maryland	2 should be it and Mental I la marked o raumatic eve	2	19a. Informant's Name/Relationship (T)	voe Print)		19b. Mailin	a Address (Street a			ural Route Number, City or Town, State, Zip Code)									
₹	d 2 s th an t7 la	n y	Dorothy C. Toler/									MD 21228							
ė,	ges 1 and 2 should t of Health and Mer If item 27 la marke or other traumatic		20a. Method of Disposition	o Po abo	20b. P	lace of Dispo	sition (Name of	1	Date		ation - City or To								
mor	Pages lent of I nt: If it ry or o		1 Burial 2 Cremation 3 II		tate	emetery, cren	natory or other place	9)											
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licens	and, p	ctor	St Ba	Name and Address ate Anato Itimore,	of Facility Dmy Boa MD 21	ard 655 W.	Bal	timore S	Street							
		-	23a. Part1. Enter the disease, or comp	lications that ca	used the death				rdiac or respiratory a	rrest,		Approximate Interval Between							
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.									Onset and Death							
	pe sit	ine	n any, leading to innectate cause. Enter Underlying Cause (Disease or injury	r as a consequ	aanoo org.														
	and and I-trans	Examiner	that initiated events resulting in death) Last	uence of):		_			-										
8760,	icate be executed physician and s the burial-transit	aiE																	
687	icate phys s the	edicai		d															
O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transi	y Physician/Me		by Physician/M	hysician/M	hysician/M	hysician/M	hysician/M	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ∐ Fetal ntattime of ol	death 3	Ectopic pregnancy Other (specify)			23	3d. Date of delive Month	ery Day Year
Δ.					Part II. Other significant conditions co	ntributing to dea	ath but not resi	ulting in the ur	iderlying cause give	en in Part I.	23e. Did t	obacco us		ne cause of death?					
Ë	w requires been sign should be	edi	cardionujopo	thy					_ 10	Yes 2□	]No 3☐Prob	ably 4 Unknown							
Division of Vital Records,	The law te has bage 2 s	Completed	3	7					24a. Was auto perfo 1 ☐ Yes		prior to co	psy findings available mpletion of cause of							
ita	Physician: This certificated director, p	Be (	25. Was case referred to medical examiner?					26. Place of	Death (Check only	one)									
<b>S</b>	S S D	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ In	patient 2 🗆	ER/Outpatien		4 U NUISII	ng Home 5 Resi			y)							
0	ng Pl fter t	ü	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month	Injury , <i>Day Year)</i>	28b. Time of Injury	28c. Injury Work	:?	28d. Tescribe	how injury	occurred								
Sio	endii eath. or: A he fu	atio	2 Accident investigation					/es 2 □ No											
Divis	Hospitel or Attending 14 hours after death. Funeral Director: Afte tely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 6 Could not be building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number of City or Town, State)								il Route Number,								
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical C	29a. Certifier (Check only one)	sician: To the bainer: On the bai	sis of examina	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and p pinion, death o	place, and due to the occurred at the time,	cause(s) a date and p	and manner as s place, and due to	tated. the cause(s)							
	withir To th	ž	29b. Signature and title of certifier				29c. License			29d. Date	signed (Month,	Day, Year)							
			Mal	/	~ > > > > > > > > > > > > > > > > > > >		D30°	189		NOV	26 50	204							
			30. Name and address of person who co	L			•	e Ln	anotan	NIVE	a MD								
	Sta Registr		31. Sab filed (Month, Day, Year)  DEC 0 6 2004	32. Re	gistrar's Signa	ture	los de												
			V U 2004	Jun 2		1.54	my water												